

FUNERAL DIRECTOR: IMPORTANT

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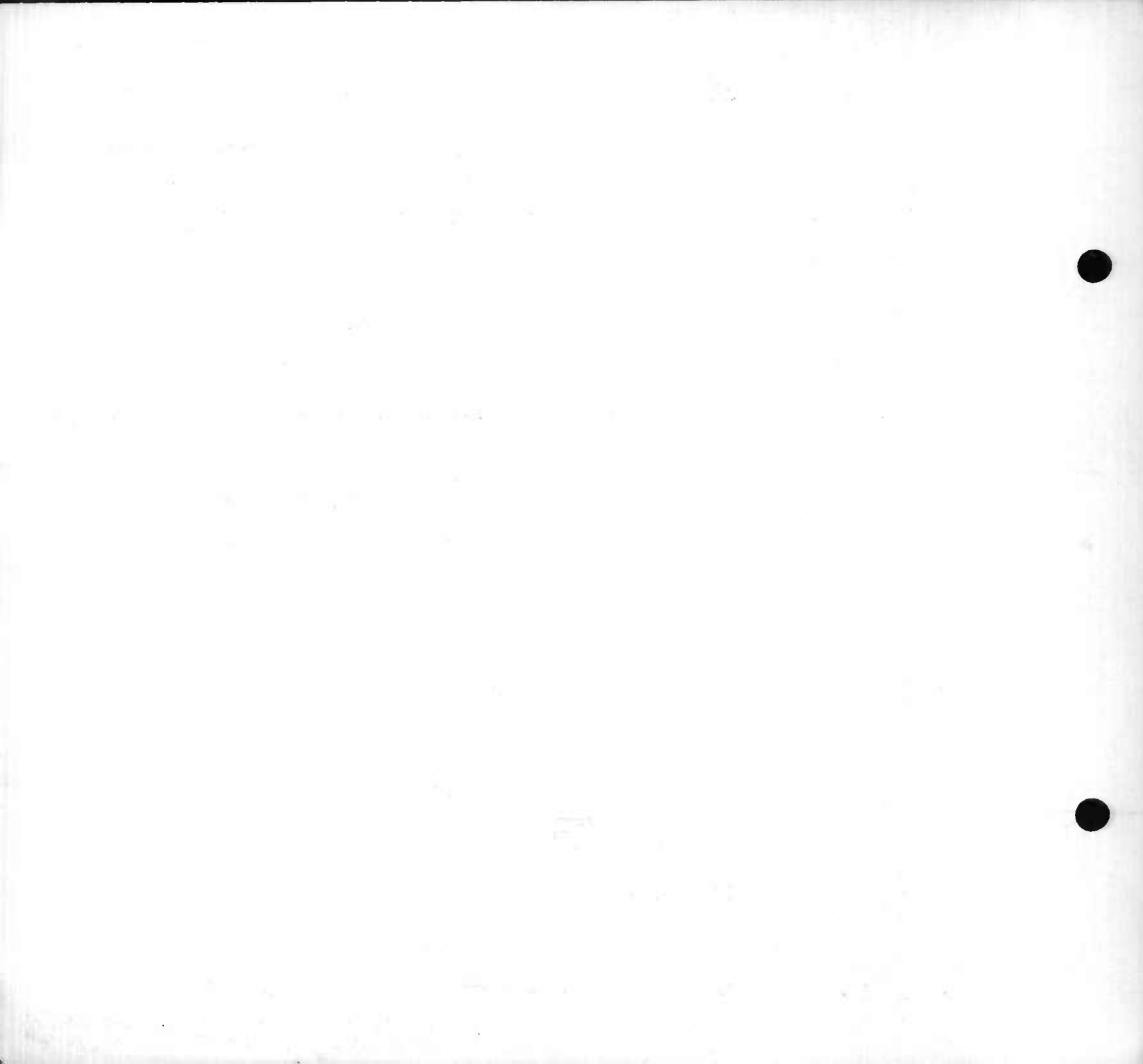
<div style="display: flex; justify-content: space-between;"> A-435 70 3501 </div>		BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.		70 3501				
1. NAME OF DECEASED (Type or Print) <u>Altman Violet T</u>						2. DATE AND HOUR OF DEATH <u>3/30/70</u> <u>3:38</u> M.								
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Granada Nursing Home</u>						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2737</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7180 McLean Blvd.</u>								
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/8/23</u>		9. AGE (in years lost birthday) <u>47</u>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>						10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>JOSEPH F. THOMAS</u>						14. MOTHER'S MAIDEN NAME <u>REBECCA THOMPSON</u>								
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>						16. SOCIAL SECURITY NO. <u>213-RR-1388</u>		17. INFORMANT <u>BERNARD ALTMAN SR.</u> ADDRESS <u>2882 MAYFIELD AVE</u>						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Adenocarcinoma, Right Frontal Lobe, Metastatic</u> (B) <u>Broncho-genic Carcinoma, Rt. Upper Lobe</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>? 1 year</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).														
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <u>25 February</u> 19 <u>70</u> to <u>30 March</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>30 March</u> 19 <u>70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>Robert L. Blackmon, M.D.</u>						23B. DATE SIGNED <u>30 March 1970</u>								
23C. PHYSICIAN'S NAME (Type) <u>ROBERT L. BLACKMON</u>						23D. ADDRESS <u>PROVIDENCE CAMP. CENTER, BALTO., MD.</u>								
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>4/2/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>				24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>				25C. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME</u> ADDRESS <u>4210 BELAIR RD</u>						



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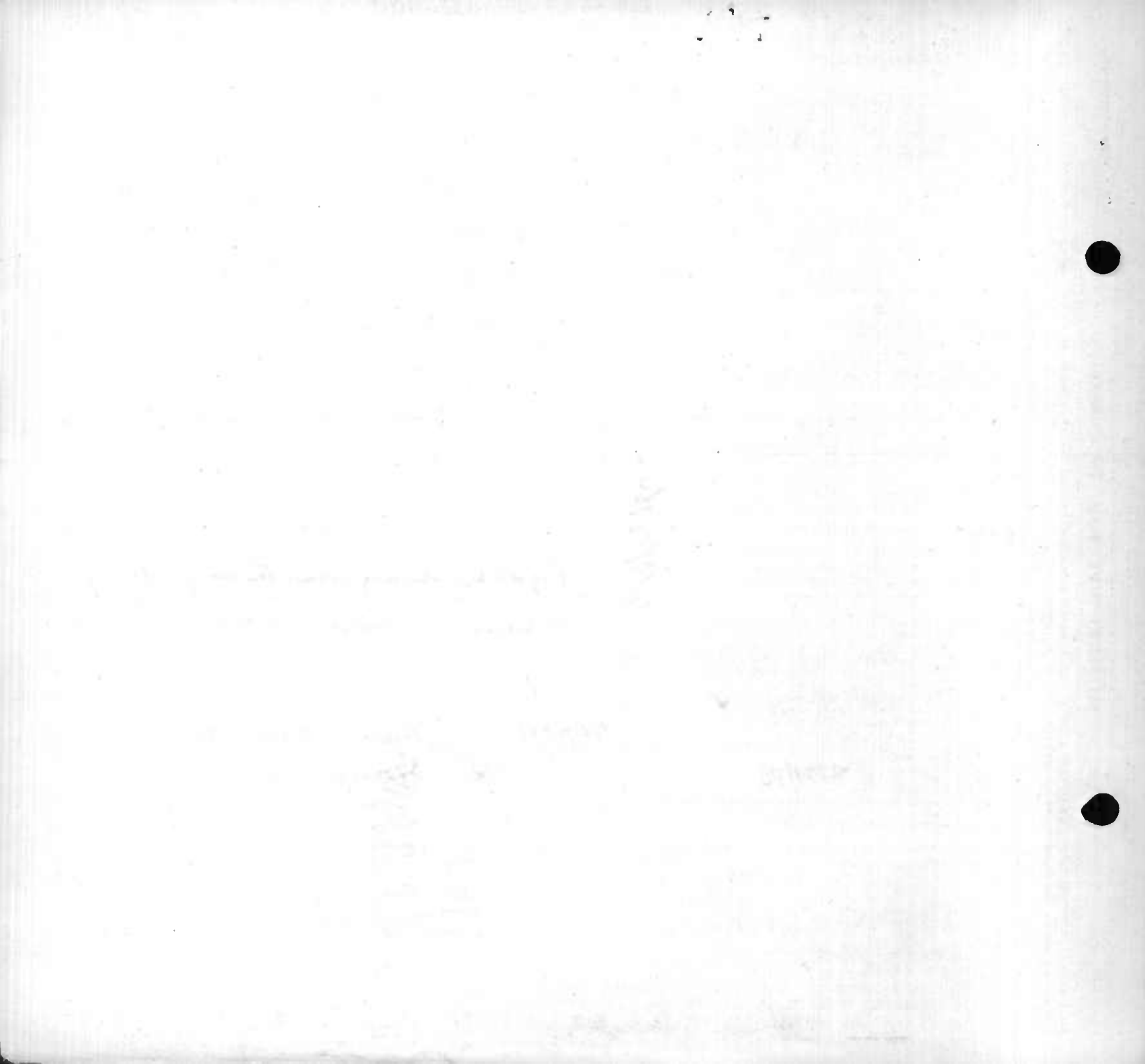
J-525 70 3502		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3502	
BIRTH NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) RUBY B. JOHNSON			2. DATE AND HOUR OF DEATH 4/1/70 1350 1 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE BALTIMORE B. COUNTY MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 3437 ROLAND AVE		
5. SEX F	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/05	9. AGE (in years last birthday) 64	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME WILLIAM BRYANT		
14. MOTHER'S MAIDEN NAME BESSIE McCORMICK			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 225-03-6411			17. INFORMANT ADDRESS CHARLES J. JOHNSON, 9307 ROLAND AVE		
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 DAYS
(A) IMMEDIATE CAUSE ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:					
(B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF:					?
(C) _____					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 3/12/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PROLAPSED VAGINAL STUMP		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/10 19 70 to 4/1 19 70 that (I) (we) last saw the deceased alive on 4/1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael C.W. Yen MD				23B. DATE SIGNED 4/1/70	
23C. PHYSICIAN'S NAME (Type) MICHAEL C.W. YEN MD				23D. ADDRESS MARYLAND GENERAL HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal/ Bur.		24B. DATE 4-4-70		24C. NAME of CEMETERY or CREMATORY FORTHILL MEMORIAL PARK	
24D. LOCATION (City, town, or county) (State) LYNCHBURG, VA.		25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR ULTRIC FUNERAL HOME / FOR LYNCHBURG, VA. BALTO, MD.		25D. ADDRESS WHITTEN FUNERAL HOME			



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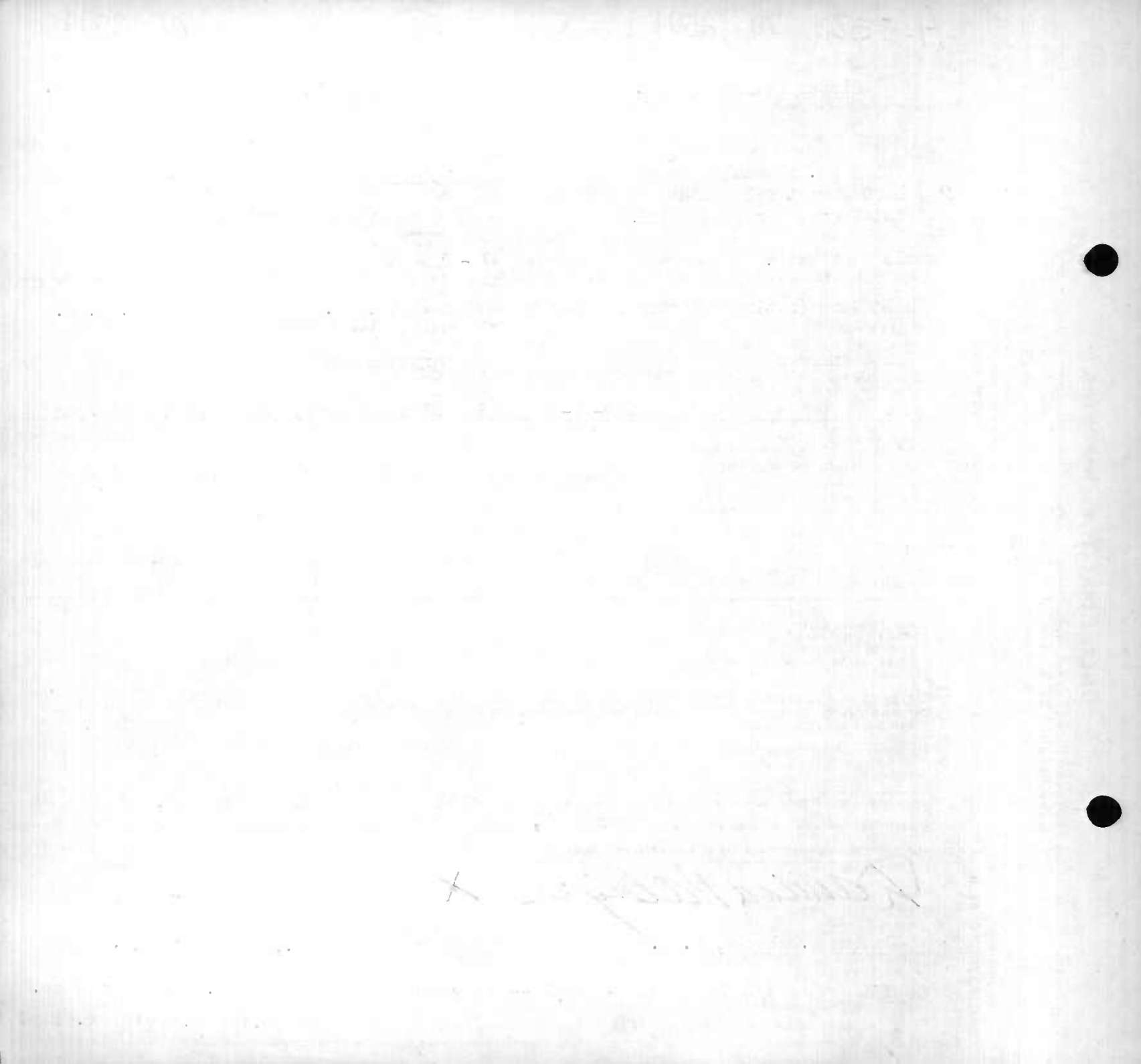
B-250 3503		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3503	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BIGHAM, BILLIE		2. DATE AND HOUR OF DEATH 3-29-70 10:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE SOUTH CAROLINA B. COUNTY V-37			
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore, Maryland 21205		C. CITY OR TOWN Rock Hall D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9/4/23 9. AGE (In years last birthday) 46	
11. BIRTHPLACE (State or foreign country) N.C., N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Boyce Bigham		14. MOTHER'S MAIDEN NAME Sarah Whitside			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Bass Funeral Home, Rockhill, N.C.	
18. 427.61 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO RESPIRATORY ARREST (B) Possibly Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF: on 3/21/70. (C) Syncope during anesthesia for biopsy. of ulcer of alveolar ridge		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 DAYS			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 3/21/70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic Ulcer Alveolar Ridge 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) hospital 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Johns Hopkins Hosp. 06-02			
21D. TIME OF INJURY (APPROX.) 3/21/70 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? Syncope during Anesthesia		22. I certify that (I) (this hospital) attended the deceased from March 13, 1970 to March 29, 1970 and that (I) (was) lost saw the deceased alive on March 29, 1970 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.			
23A. SIGNATURE @ Bhushan		23B. DATE SIGNED March 29, 1970		23C. PHYSICIAN'S NAME (Type) CHHABI BHUSHAN	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Removal		24B. DATE 3/31/70		24C. NAME of CEMETERY or CREMATORY Laurelwood Cemetery	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Bass Funeral Home, Rockhill, S.C.	
25D. ADDRESS Bass Funeral Home, Rockhill, S.C.		25E. ADDRESS Bass Funeral Home, Rockhill, S.C.			



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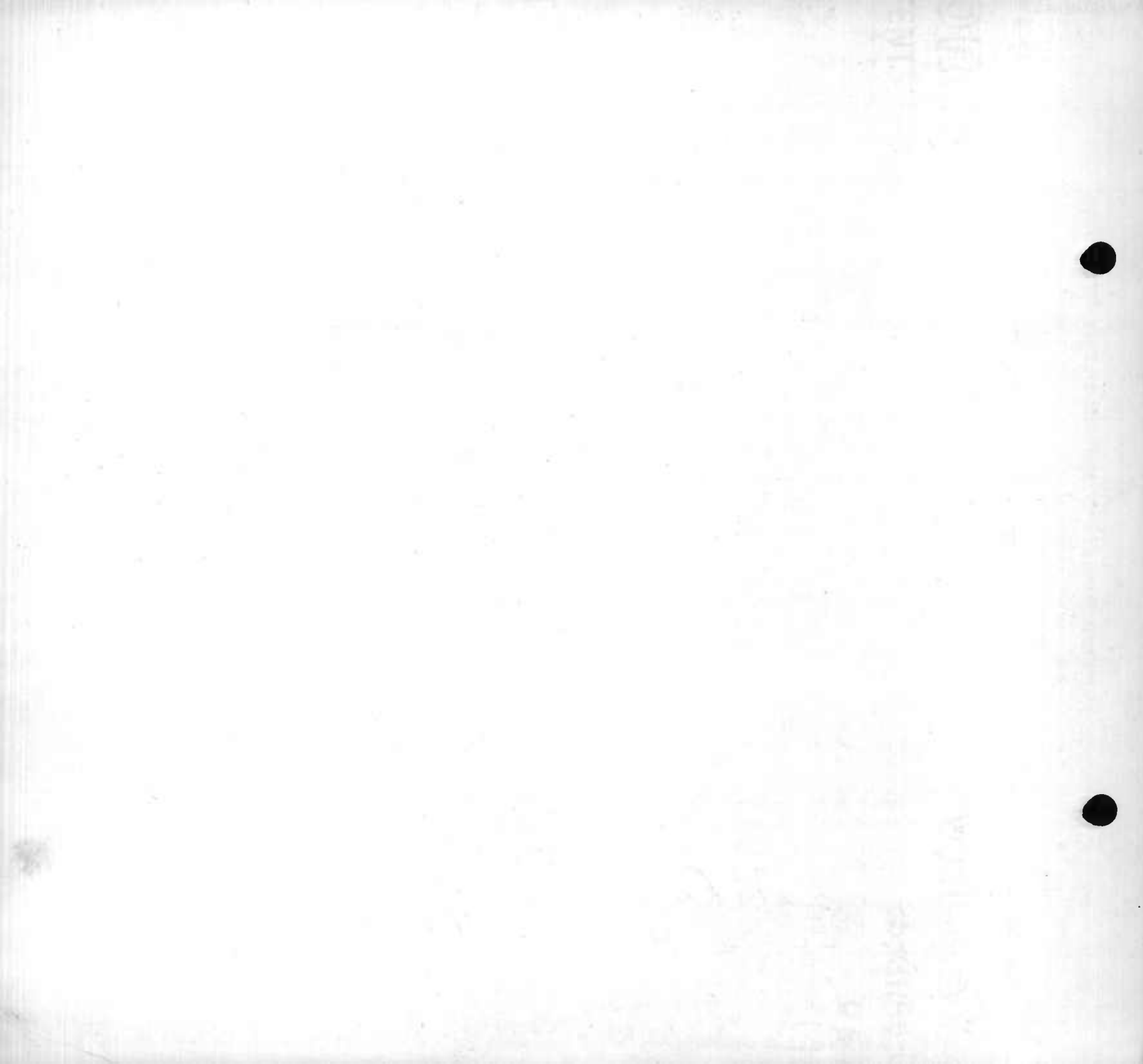
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3504	
A-536 70 3504		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Sister Rosina Andrews		2. DATE AND HOUR OF DEATH April 1, 1970 9:05 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Villa St. Michael 4000 Forest Hill Road Baltimore, Maryland 21207		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4000 Forest Hill Road			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 - 1 - 70	9. AGE (In years last birthday) 99	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child Care (retired)		10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity		11. BIRTHPLACE (State or foreign country) Titusville, Pa.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Jacob Andrews		14. MOTHER'S MAIDEN NAME Mary Hinchey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-2067 J 1		17. INFORMANT Sister Andrea, 4000 Forest Hill Road	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(A) IMMEDIATE CAUSE Right Pneumonitis DUE TO, OR AS A CONSEQUENCE OF: (B) Cardio Vascular Collapse DUE TO, OR AS A CONSEQUENCE OF: (C) None		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 day	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19 52 to March 31, 19 70, that (I) (we) last saw the deceased alive on March 31, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Damian P. Alagia, M. D.		23B. DATE SIGNED April 1, 1970		23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M. D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/3/70		24C. NAME OF CEMETERY or CREMATORY VILLA-SETON -- on grounds of Seton Inst. 6400 Wabash Av.	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR P. E. Barber, M.D.		25C. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av. Cktyl	



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B-320 70 3505				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3505	
BIRTH NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				(Type or Print) <i>Marie Bates</i>		<i>March 31 1970</i> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE <i>Maryland</i> B. COUNTY <i>808</i>			
<i>1230 N. Gay Street</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <i>1230 N. Gay Street</i>			
5. SEX <i>Female</i>		6. RACE <i>-</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-25-1892</i> 9. AGE (In years lost birthday) <i>77</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Media Co. Va.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lloyd Lee Bates</i> ADDRESS	
18. <i>4-10-9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute myocardial Infarction</i>		<i>Instant</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Arteriosclerosis -</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>15 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) _____			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>2-25-1970</i> to <i>3-30-1970</i> , that (I) (we) last saw the deceased alive on <i>3-5-70</i> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Eugene H. Owens</i> DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4-2-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Eugene H. Owens</i> DEGREE				23D. ADDRESS <i>1735 E. Federal St</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-3-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cmt</i>		24D. LOCATION (City, town, or county) (State) <i>Balt Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 3 1970</i>		25B. NAME OF REGISTRAR <i>Blaise E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Colville J. Brantley Jr</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3506</u>	
BIRTH NO. <u>1-120 70 3506</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>JAMES GEORGE TOBIAS</u>		2. DATE AND HOUR OF DEATH <u>March 31, 1970 12:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME & HOSPITAL 35</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE & COUNTY <u>MARYLAND, USA 203</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>831 S. Bond St. (31)</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/22/05</u>	9. AGE (In years last birthday) <u>64</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired Marine Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Unknown Henry Tobias</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>217-14-2157</u>		17. INFORMANT (Name) <u>Mary Helinski</u> Address <u>2401 Foster Ave.</u>	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Massive myocardial infarction and pulmonary edema</u> (B) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Indefinite</u> (C) <u>Possible Pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Indefinite</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs (?)</u> <u>Indefinite</u> <u>Indefinite</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>March 31, 1970</u> to <u>March 31, 1970</u> that (1) (we) last saw the deceased alive on <u>March 31, 1970</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rolando A. Mendez</u>		23B. DATE SIGNED <u>3/31/70</u>		23C. PHYSICIAN'S NAME (Type) <u>ROLANDO A. MENDOZA, MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-4-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Washington Memorial</u>	
24D. LOCATION <u>Coram, Long Island, New York</u>		24E. ADDRESS <u>100 N. Broadway, Baltimore, MD 21231</u>		24F. DATE REC'D BY HEALTH DEPT. <u>APR 3 1970</u>	
24G. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		24H. FUNERAL DIRECTOR <u>Lilly & Zeiler Inc.</u>		24I. ADDRESS <u>1901-07 Eastern Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

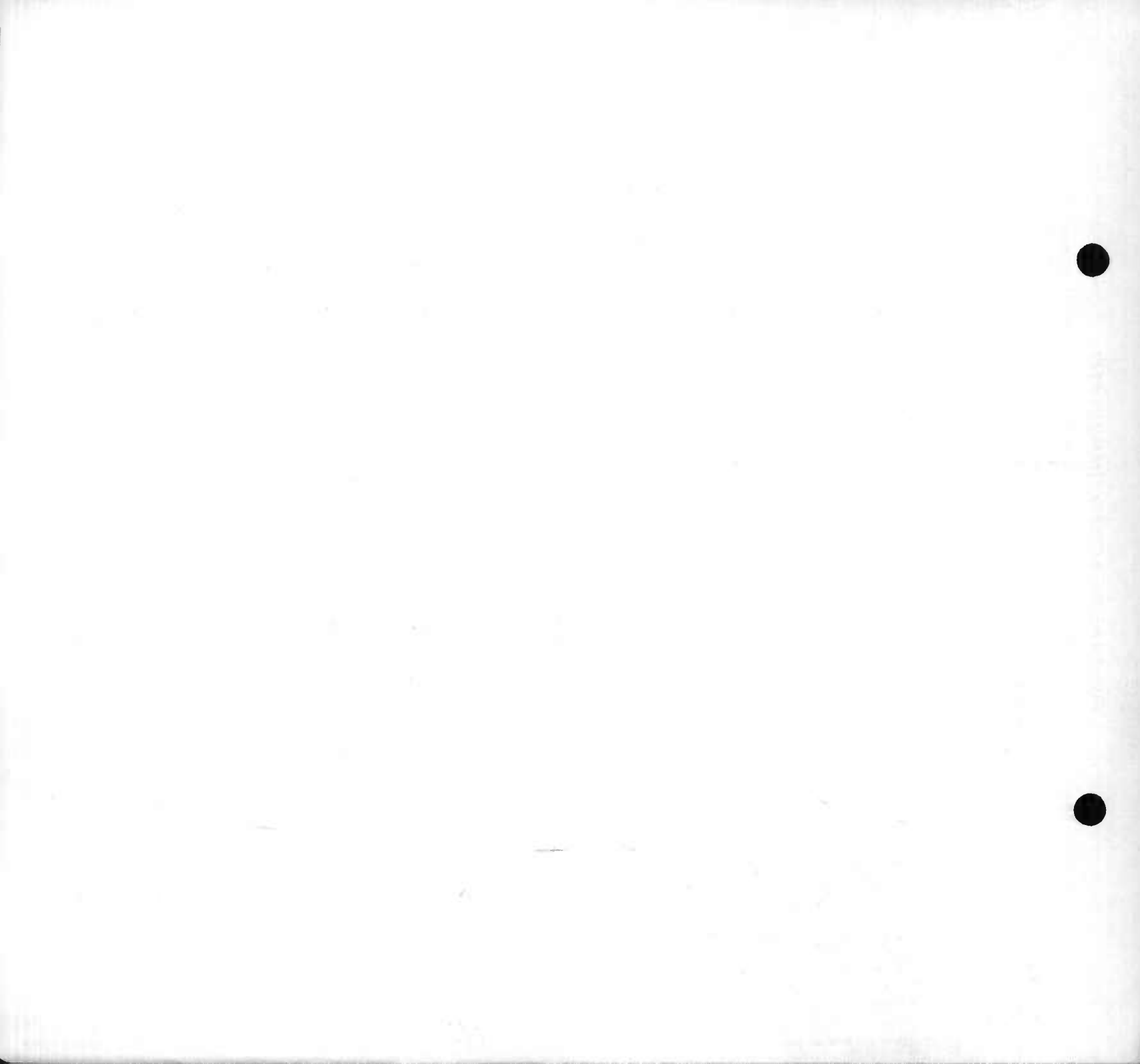
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3507	
BIRTH NO. P-626 70 3507		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) pRICHARD, Agnes		2. DATE AND HOUR OF DEATH 3/31/70		11:55 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 704 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 926 N. Broadway			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/30/16	9. AGE (in years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kresser		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Miller Jones		14. MOTHER'S MAIDEN NAME Lizzie Stunker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Sam McCray-926 N. Broadway	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.9 I CAUSE OF DEATH (A) IMMEDIATE CAUSE SUBARACHNOID HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF: (B) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASPIRATION PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/30 19 70 to 3/31 19 70 that (I) (we) last saw the deceased alive on 3/31/70 11 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harvey G. Klein M.D.		23B. DATE SIGNED 5/31/70		23C. PHYSICIAN'S NAME (Type) Harvey G. Klein, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 4/4/70		24C. NAME OF CEMETERY OR CREMATORY Kingstree, South Carolina	
25A. DATE REC'D BY HEALTH DEPT. ADD 3 1970		25B. NAME OF REGISTRAR J. E. E. Taylor, M.D.		25C. FUNERAL DIRECTOR J. E. E. Taylor-1129 N. Caroline St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3508</u>	
BIRTH NO. <u>B-240 70 3508</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WILLIAM BAGLEY</u>			2. DATE AND HOUR OF DEATH <u>APR 1, 1970 6:30 A.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTO</u> <u>42</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>1607</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3116 NORMOUNT AVE</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/199</u>	9. AGE (In years last birthday) <u>70</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRANE OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JAMES BAGLEY</u>			14. MOTHER'S MAIDEN NAME <u>NANIE (UNKNOWN)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-07-0206</u>	17. INFORMANT <u>GERTUDE BAGLEY</u> ADDRESS <u>3116 NORMOUNT AVE</u>		
18. <u>412.4 L 0930</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>ASCVD</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Luetic Aortitis</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <u>2</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from <u>MARCH 27, 1970</u> to <u>APRIL 1, 1970</u> that (he) (we) last saw the deceased alive on <u>APRIL 1, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gerald A. Hokin MD</u>			23B. DATE SIGNED <u>APR 1, 1970</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Typal) <u>GERALD A. HOKIN, M.D.</u>			23D. ADDRESS <u>3502 West ROGERS AVE BALTIMORE, Md. 21215</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>4/4/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>A.A. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert J. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Milton Edmiston</u> ADDRESS <u>11297 Caroline St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

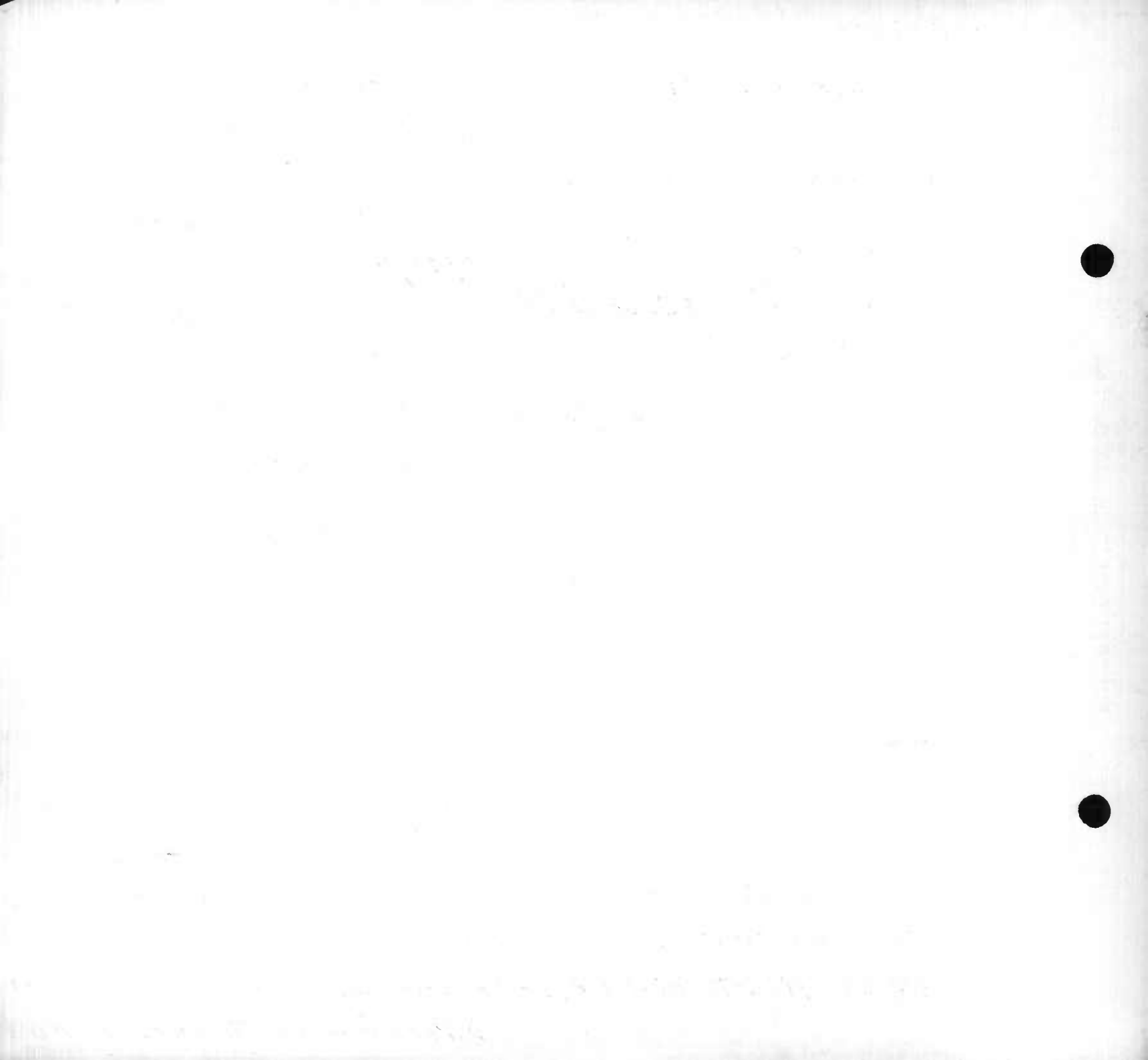
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3509	
J-525 70 3509 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) JOHNSON EDWIN W			2. DATE AND HOUR OF DEATH 4-2-78 10⁰⁵-A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GEN. HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 21214 2706		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 6108 FAIR OAKS AVE.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-8-07	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Wm B. JOHNSON			14. MOTHER'S MAIDEN NAME FLORENCE J. WHITE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 291-05-7211	17. INFORMANT WIFE - PAULINE JOHNSON - SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ARTERIO SCLEROTIC HEART DISEASE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHRONIC OBSTRUCTIVE LUNG DISEASE CARCINOMA OF BLADDER					
19A. DATE OF OPERATION 3-21-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natty medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) 4-2-70		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from 3-21 19 70 to 4-2 19 70 and that (I) (we) last saw the deceased alive on 4-2 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Angela A. Topacio			23B. DATE SIGNED 4-2-78		23C. PHYSICIAN'S NAME (Type) ANGELA TOPACIO
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE APR 6-70		24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH CEM
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970			25B. NAME OF REGISTRAR P. E. Taylor, Jr.		25C. FUNERAL DIRECTOR DIPPEL BROS INC 7110 BELAIR RD
24D. LOCATION (City, town, or county) (State) MARYLAND GEN. HOSPITAL			24E. LOCATION (City, town, or county) (State) TRUMPS MILL RD. MD.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3510	
D-500 3510		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) RITA M. DIEM		04-1-70 6:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL		A. STATE MARYLAND B. COUNTY U.S.A.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN JOPPA D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
44		E. STREET AND NUMBER 1002 BEALL DRIVE 21085	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-18-09
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE	9. AGE (In years last birthday) 61
11. BIRTHPLACE (State or foreign country) SCOTLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN.	
13. FATHER'S NAME MACNALLY		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 086169146	
17. INFORMANT HUSBAND		ADDRESS SAME AS ABOVE	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIORESPIRATORY ARREST	
		(B) METASTATIC CANCER TO LIVER DUE TO, OR AS A CONSEQUENCE OF:	
		(C) COLON CANCER	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 03-31 19 70 to 04-1 19 70 that (I) (we) last saw the deceased alive on 04-1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Yasumasa Yamasaki M.D.		23B. DATE SIGNED April-1 '70	
23C. PHYSICIAN'S NAME (Type) YASUMASA YAMASAKI M.D.		23D. ADDRESS 33RD AND CALVERT STS BALTO. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE APR 4-70	24C. NAME of CEMETERY or CREMATORY HOLY REDEEMER CHURCH	24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD BALTO MD
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR DIPREG BROS INC 7110 BELAIR RD	



FUNERAL DIRECTOR: IMPORTANT

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CERTIFICATE AMENDED 4/28/70

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3511	
C-160 70 3511		BIRTH NO.		70 3511	
1. NAME OF DECEASED (Type or Print) COOPER, DANIEL, JR.			2. DATE AND HOUR OF DEATH 4/1/70 5:25 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 805 CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1907 Regester Street		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/8/23	9. AGE (In years last birthday) 46	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME DANIEL			14. MOTHER'S MAIDEN NAME Lillian Clark 818 Mc Donough St		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 6/2/43 - Dec 25/45			16. SOCIAL SECURITY NO. 17-19-0737		
17. INFORMANT INEZ COOPER 818 Mc Donough St			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E 814.71 Multiple Traumatic Injuries Cerebral Collapse Antecedent Causes DISEASES OR CONDITIONS, if any, during rise to the above cause (A) stating the UNDERLYING CONDITION lost. Cerebral Hemiparesis Chronic Alcoholism & Trauma Cirrhosis of Liver			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo 1 mo		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/17		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED G.E. bleeding		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Yes		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1300 Block Orleans St. 6-05 Unknown Balt. Street	
21D. TIME OF INJURY (APPROX.) 2/19/70 1700		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Pedestrian hit by car It was struck by car which intended to turn right	
22. I certify that (I) (this hospital) attended the deceased from 2/19/70 to 4/1/70 and that (I) (we) last saw the deceased alive on 4/1/70 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Fee MD			23B. DATE SIGNED 4/1/70		
23C. PHYSICIAN'S NAME (Type) H. Fee MD			23D. ADDRESS Johns Hopk Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/6/70		24C. NAME OF CEMETERY OR CREMATORY Balto. National Cem.	
24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave		25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Joseph B. Loebe		25D. ADDRESS 1304 N. Randolph St.			

Marriage cert of Daniel Cooper, Jr. & Inez Waters--7/12/46 in Balto. Md.
Certified statements from Clerks of both Circuit Courts of Balto. City
that their records show that no divorce had taken place or was pending between
both parties stated above in their courts.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3512

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

NORMAN H. TRENT

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

9:45 p. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Mercy Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

March 30, 1970

9:45 p. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☐NO ☐

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

2/22/41

10. AGE (In years
last birthday)

29

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Trent

14A. USUAL OCCUPATION (Give kind of work
done during 1 year preceding death, if retired)

Unemployed

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sally

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

Mrs Sally Trent, Same

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
Shot wound of the head
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Fay St. N. of Baltimore St.

22D. TIME
OF INJURY
(APPROX.)

3 30 70 9:30p

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

XX Subject shot during altercation with
policeI certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/31/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/4/70

24C. NAME OF CEMETERY or CREMATORY

MT Auburn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 3 1970

25B. NAME OF REGISTRAR

J. E. Faber, M.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W north Ave

ADDRESS

ACADEMY OF MUSIC

PROVIDENCE, R.I.

WILFRED

1912

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-363 70 3513		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3513	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Edward, Alberta</i>		2. DATE AND HOUR OF DEATH <i>4/1/70 2:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1504</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BALTIMORE CITY HOSPITALS</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>4-10-97</i>		9. AGE (In years last birthday) <i>72</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Glen Bates</i>		14. MOTHER'S MAIDEN NAME <i>Laura Bowers</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>BCH-Records 4940 Eastern Avenue Baltimore, Maryland 21224</i>	
18. <i>23-071</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>namany tract infection, suspected left AK Amputation</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes mellitus</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2/3/3</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>gangrene left foot</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <i>4/1/70</i> to <i>4/1/70</i> that (1) (we) last saw the deceased alive on <i>4/1/70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Edward J. Lee MD</i>	
23B. DATE SIGNED <i>4/1/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Edward J. Lee MD</i>		23D. ADDRESS <i>BCH- 4940 Eastern Avenue Baltimore, Maryland 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/6/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Newberry</i>	
24D. LOCATION (City, town, or county) (State) <i>South Carolina</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 3 1970</i>		25B. NAME OF REGISTRAR <i>John E. Fisher, Jr.</i>	
25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>		25D. ADDRESS <i>1206 W north Ave</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 3514

F-430

70 3514

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

FLOYD, Lawrence

2. DATE AND HOUR OF DEATH

March 25, 1970

12:15 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90

Bolton Hill Nursing & Convalescent Ctr.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

1038 Pennsylvania Avenue

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

M

6. RACE

Negro

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

July 15, 1920

9. AGE (In years last birthday)

49

If Under 1 Yr. Months

If Under 24 Hrs. Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218-07-6437

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma floor mouth

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-18-70 1970 to 3-25 1970, that (I) (we) last saw the deceased alive on 3-25 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

E. Ellsworth Cook M.D.

Attending Phys. ☐

Med. Director ☒

Staff Phys. ☐

23B. DATE SIGNED

3-25-70

23C. PHYSICIAN'S NAME (Type)

E. Ellsworth Cook M.D.

23D. ADDRESS

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL

24A. BURIAL CREMATION REMOVAL (Specify)

24B. DATE

3-31-70

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

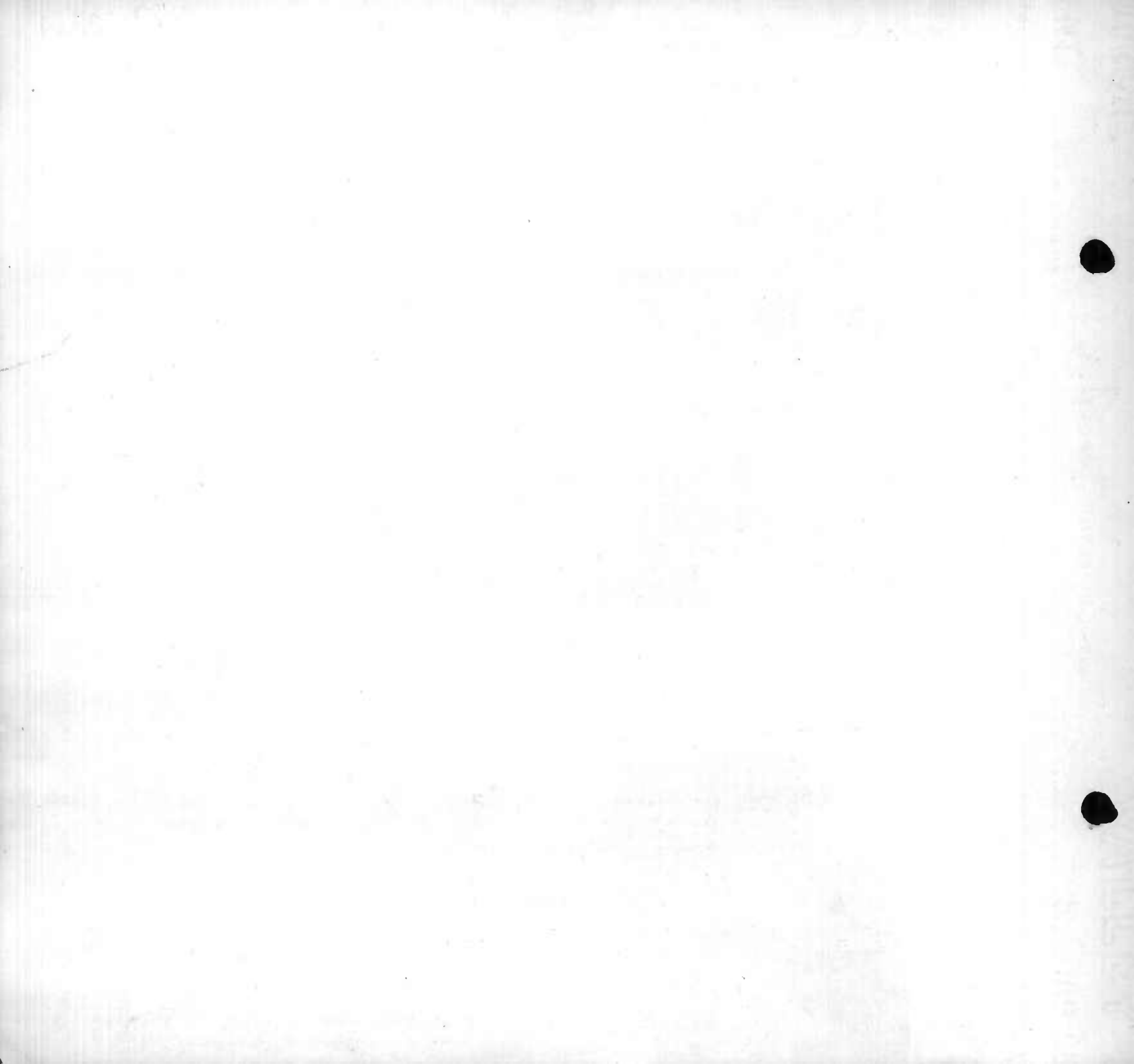
APR 3 1970

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHD



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
NORBERT T. ACKERMAN		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		Month Day Year Hour		A. STATE B. COUNTY	
				3 2 70 10:15 A.M.		Md. 2201			
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
		60						311 S. Sharp St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS			
19. 412.4		CAUSE OF DEATH		Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		DUE TO, OR AS A CONSEQUENCE OF:					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(B)		DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(C)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED			
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
Russell S. Fisher, M.D.									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY		24D. LOCATION (City, State or County) (State)			
		3-31-70							
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 3 1970		Russell S. Fisher, M.D.							

ACADEMY BOOK

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F-200 70 3516		BALTIMORE CITY HEALTH DEPARTMENT		70 3516	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print)		JOHN FOSS		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		606 Washington Boulevard		3. DATE PRONOUNCED DEAD Month Day Year March 5, 1970 Hour 2:10 A. M.	
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10. AGE (In years last birthday) 50		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 571.81 CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE Lobar pneumonia DUE TO, OR AS A CONSEQUENCE OF:			
		(B) Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 5, 1970	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 3-31-70		24C. NAME OF CEMETERY	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCMD	

ACADEMY FOUND

USE CONTIN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3517</u>
B-61670-05459 3517 BIRTH NO. [REDACTED]		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Barbry</u>		2. DATE AND HOUR OF DEATH <u>March 27, 1970 5:45 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>none</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3209 Belmont Ave 21216</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-70</u>	9. AGE (In years last birthday) <u>1 day</u> II Under 1 Yr. Months: Days: <u>23</u> II Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Joseph Barbry</u>		14. MOTHER'S MAIDEN NAME <u>Esther (Barbry) Franklin</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Resp. Distress Synd.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~16 hrs.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Prematurity</u> <u>2° to cervical immcompetence</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>3-26</u> 19 <u>70</u> to <u>3-27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3-27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Polly B. Roberts MD</u>			23B. DATE SIGNED <u>3-27-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Polly B. Roberts</u>			23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>JOHNS HOPKINS MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-3-70</u>		24C. NAME of CEMETERY or CREMATORY
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3518	
B-620 70-0546970 3518				REG. NO.	
BIRTH NO.				70-0546970 3518	
1. NAME OF DECEASED (Type or Print) <u>BABY BOY BRICE</u>			2. DATE AND HOUR OF DEATH <u>3-30-70</u> <u>6 15</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>833</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY OF MARYLAND</u> <u>38</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>M</u> 6. RACE <u>N N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			E. STREET AND NUMBER <u>2638 Beryl Ave Balt 21205</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			8. DATE OF BIRTH <u>3-28-70</u> 9. AGE (in years last birthday) <u>1</u> 10. Under 1 Yr. Months <u>1</u> Days <u>13</u> 11. Under 24 Hrs. Hours <u>53</u> Min.		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		
13. FATHER'S NAME <u>Charlie Brice Jr.</u>			12. CITIZEN OF WHAT COUNTRY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME <u>SYLVIA BRICE Smith</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
18. <u>776.1 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <u>HYALINE MEMBRANE DIS.</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <u>PREMATURITY</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-28</u> 19 <u>70</u> to <u>3-30</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3-30</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Felix L. Kaufman M.D.</u>			23B. DATE SIGNED <u>3-30-70</u>		
23C. PHYSICIAN'S NAME (Type) <u>FELIX L. KAUFMAN M.D.</u>			23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>4-3-70</u>			24B. DATE <u>4-3-70</u>		
24C. NAME OF CEMETERY OR CREMATORY			24D. LOCATION (City, town, or county) (State) <u>JOHNS HOPKINS MEDICAL SCHOOL</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		
25C. FUNERAL DIRECTOR			25D. ADDRESS <u>MORTUARY SERVICE - BCHA</u>		



S-415 1

70 3519

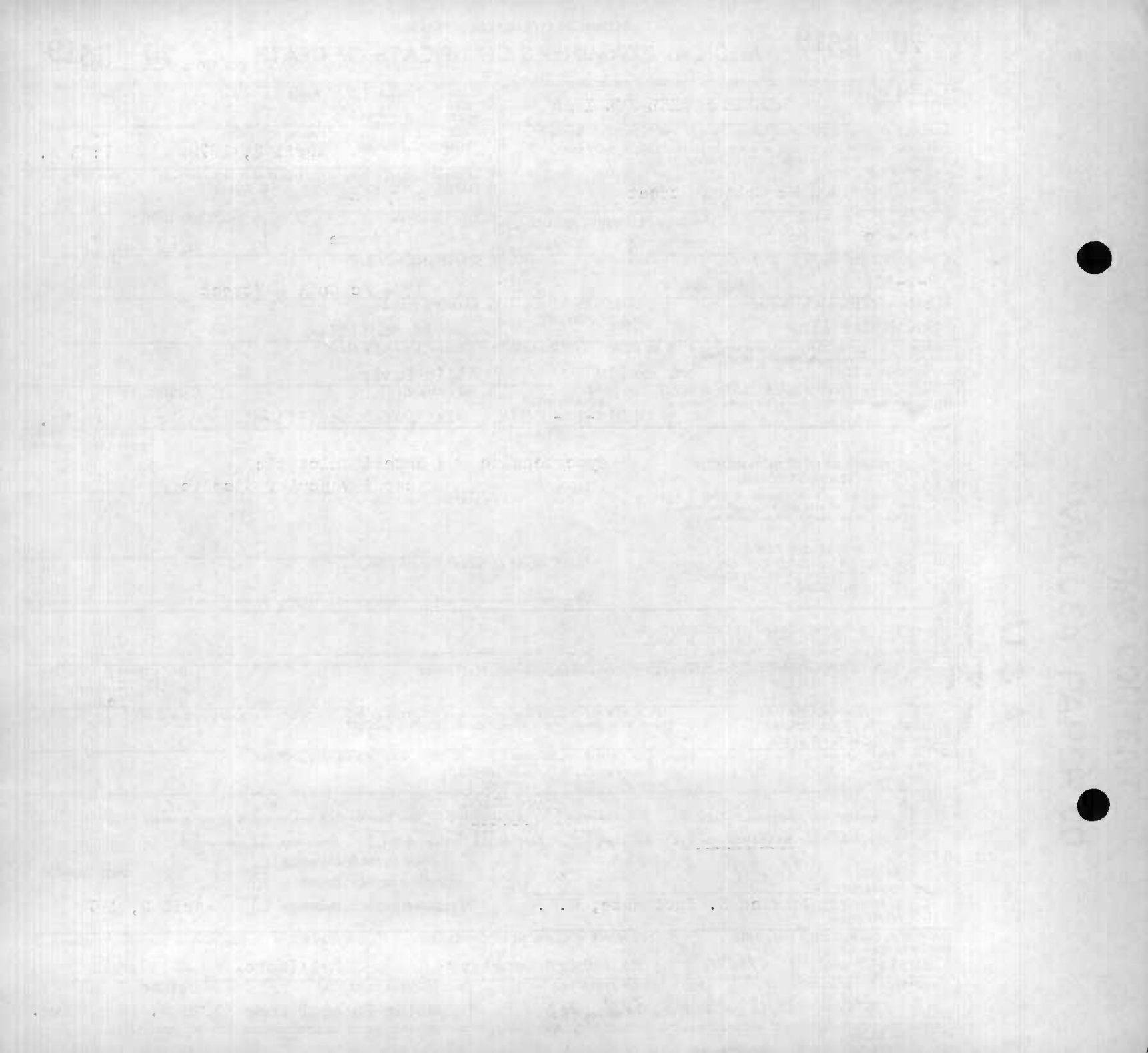
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3519

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIE MURIEL SULLIVAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1806 Mc Culloh Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 2, 1970 7:03 A.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1403	
9. DATE OF BIRTH 8-3-11		10. AGE (In years last birthday) 58 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		148. KIND OF BUSINESS OR INDUSTRY Pvt Family	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 214-14-2527A	
13. FATHER'S NAME David McMillian		15. MOTHER'S MAIDEN NAME Allie Davis	
18. INFORMANT Miss Sarah McMillian		ADDRESS 1806 Mc Culloh St.	
19. CAUSE OF DEATH 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic (A) IMMEDIATE CAUSE cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) DATE SIGNED April 2, 1970		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/4/70	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Nutter Funeral Home		ADDRESS 3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3520		REG. NO. 70 3520	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		HOWARD TURNER		3/31/70		4.30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
UNIVERSITY OF MARYLAND HOSPITAL				BALTIMORE		1601	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				505 N. CARROLLTON ST. 21223			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.	
MALE	NEGRO	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8/25/97	72		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
SPICE FACTORY				MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JENIFER TURNER				MARY ELIZABETH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
WWII		215-05-1667A		MARIE DIAS - 505 N. CARROLLTON ST.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
433.01				BRAIN STEM THROMBOSIS			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(H.A.V.D) HYPERTENSIVE ARTERIOCLEROTIC VASCULAR DISEASE			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				CHRONIC PYELONEPHRITIS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/30/70 1970 to 3/31 1970 that (I) (we) lost saw the deceased alive on 3/31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Andrew M. Doyle				3/31/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
ANDREW H. DOYLE		UNIVERSITY OF MD. HOSP. BALTIMORE, MD.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-6-70		Baltimore National Cem.		Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
APR 3 1970		Robert E. Taylor, Md.		Nutter Funeral Home 3035 W. North Avenue			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

ANGELE NANCE

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Bon Secours Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

March 28, 1970

9:15 A.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

Female

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

11-19-69

10. AGE (in years
last birthday)11 Under 1 Yr. 12 Under 24 Hrs.
Months Days Hours Min.

4

E. STREET AND NUMBER

624 N. Pulaski St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Frenchie Gray

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Inell Nance

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Sadie Nance 624 N. Pulaski Street

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Sudden death in infancy
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-28-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-2-70

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Baltimore Co.,

Md

25A. DATE REC'D BY HEALTH DEPT.

APR 3 1970

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Nutter Funeral Home 3035 W. North Ave.

1. Name of the person or organization making the report

2. Title of the report

3. Date of the report

4. Place of the report

5. Name of the person or organization to whom the report is made

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 3522</u>	
BIRTH NO. <u>70 3522</u>					
1. NAME OF DECEASED (Type or Print) <u>Harding, Sylvester (Junius S. Carter)</u>		2. DATE AND HOUR OF DEATH <u>3-28-70 11:55 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>42 SINAI Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>USA</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI Hospital</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3803 BELLE GUE 414</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-8-10</u>	9. AGE (In years last birthday) <u>60</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Stone Quarry</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Sylvester Carter</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Harding</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-12-3034</u>		17. INFORMANT <u>Mrs. Evelyn Carter</u> ADDRESS <u>24 Shipley Avenue</u>	
18. <u>436.9 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>PNEUMONIA</u> <u>CEREBROVASCULAR</u> <u>Accident</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 18 19 70</u> to <u>March 28 19 70</u> that (I) (we) last saw the deceased alive on <u>March 28 19 70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Yano</u>				23B. DATE SIGNED <u>3-28-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ZITA YORRO</u>		23D. ADDRESS <u>MD SINAI Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-3-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Nutter Funeral Home</u> ADDRESS <u>3035 W. North Ave.</u>	



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3523

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70

3523

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JAMES L. WALLACE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 3 27 70 12:50 a.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour March 27, 1970 12:50 a.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10/12/26		10. AGE (In years lost birthday) 43	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Handler		14B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1945 - 1948		17. SOCIAL SECURITY NO. 215-22-7126	
18. INFORMANT Arvey Wallace		ADDRESS 600 Brice Street	
19. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) YES	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/27/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/31/70	
24C. NAME OF CEMETERY or CREMATORY Arlington National Cemetery		24D. LOCATION (City, town, or county) (State) Arlington, Virginia	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 North Monroe St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
70 3524 CERTIFICATE OF DEATH					REG. NO. 70 3524									
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <u>Moses Montgomery</u>					2. DATE AND HOUR OF DEATH <u>March 28-1970</u> <u>8:00</u> <u>A</u> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>808</u>									
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 House-In-The-Pines - Bel Aire Maryland</u>					C. CITY OR TOWN <u>Baltimore</u>					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
5. SEX <u>Male</u>					6. RACE <u>Colored</u>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>					10B. KIND OF BUSINESS OR INDUSTRY					8. DATE OF BIRTH <u>July 4, 1897</u>				
										9. AGE (In years last birthday) <u>72</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
										11. BIRTHPLACE (State or foreign country)				
										12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Moses Montgomery Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Nancy Wells</u>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 11</u>					16. SOCIAL SECURITY NO. <u>197-05-4019</u>					17. INFORMANT <u>Barbara Garrison - 4909 Palmer Avenue</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>436.9 I</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Brain Syndrome</u>					CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Generalized Arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>months</u> <u>years</u> <u>years</u>				
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <u>No</u>				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (the deceased) attended the deceased from <u>3/27/1970</u> to <u>3/28/1970</u> that (I) (we) last saw the deceased alive on <u>3/27/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.														
23A. SIGNATURE <u>Albert B. Bradley</u>					23B. DATE SIGNED <u>3/30/70</u>					23C. PHYSICIAN'S NAME (Type) <u>ALBERT B. BRADLEY, M.D.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>4/2/70</u>					24C. NAME OF CEMETERY or CREMATORY <u>Baltimore Nat'l Cemetery</u>				
24D. LOCATION <u>Baltimore, Maryland</u>					25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1970</u>					25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>				
25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u>					25D. ADDRESS <u>1727 N. Monroe Street</u>									

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LEROY KEYES		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1318 Pennsylvania Avenue		3. DATE PRONOUNCED DEAD Month		Day	Year	Hour 7:40 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1703							
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 3-19-17		10. AGE (In years last birthday) 53		E. STREET AND NUMBER 1318 Pennsylvania Avenue			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Keyes			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Lillian Mary Keyes			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Nellie Sanders 864 Sebbins Ave.			
19. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Fatty metamorphosis of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 3/31/70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-2-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

ALFRED J. BROWN

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H-300 70 3526 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 3526

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BESSIE HEATH

2. DATE
OF
DEATHKnown ☐

Month

Day

Year

Hour

M.

Estimated ☐

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

March 31, 1970

12:45 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

8/5/11

10. AGE (In years,
lost birthday)

60

If Under 1 Yr. II Under 24 Hrs.
Months, Days, Hours, Min.

E. STREET AND NUMBER

63 W. West Street

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Turner Heath

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Florence

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Virginia Hobbs 1203 S. Hanover St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
 resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/1/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

4.4.70

24C. NAME of CEMETERY or CREMATORY

Carver Memorial Pk.

24D. LOCATION

(City, town, or county)

(State)

Laurel Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 8 1970

R. E. Taylor, M.D.

Charles A. Rice 661 W. Barre St.

UNITED STATES DEPARTMENT OF JUSTICE

ALCOHOLIC BEVERAGES

ALCOHOLIC BEVERAGES

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 3527					
BIRTH NO.													
1. NAME OF DECEASED (Type or Print) CLAUDE ROOK						2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.							
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (GIVE STREET ADDRESS OR LOCATION) 732 Dover Street 5-7-70						3. DATE PRONOUNCED DEAD Month Day Year Hour April 1, 1970 4:00 P. M.							
5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2101													
6. SEX Male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
9. DATE OF BIRTH 4-1-33			10. AGE (In years last birthday) 37		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Richard Rooks			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						14B. KIND OF BUSINESS OR INDUSTRY			15. MOTHER'S MAIDEN NAME Perlie				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO. 245-42-4879		18. INFORMANT Virginia Rooks			ADDRESS 732 Dover St.				
19. 345.9 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) = Fatty metamorphosis of liver = (A) IMMEDIATE CAUSE Epilepsy DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes													
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> April 2, 1970													
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/6/70		24C. NAME OF CEMETERY or CREMATORY Seaboard			24D. LOCATION (City, town, or county) (State) North Carolina					
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970				25B. NAME OF REGISTRAR Robert E. Farber, M.D.				25C. FUNERAL DIRECTOR Charles A. Rice				ADDRESS 661 W. Barre St.	

Letter from M.E.'s office

5-7-70

M.H.

Y

C-462 70 3528		BALTIMORE CITY HEALTH DEPARTMENT	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 3528	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print) JAMES CLARK		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year April 1, 1970 10:45 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month Day Year April 1, 1970 10:45 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2001	
9. DATE OF BIRTH 3-7-1900		10. AGE (In years lost birthday) 70	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles A. Clark		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Local 557	
15. MOTHER'S MAIDEN NAME Mary L. Smith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Anna Belle Clark 1826 W. Fairmount Av.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 250.0 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. DATE SIGNED April 2, 1970 EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-9-70	
24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		25D. ADDRESS 661 W. Barre St.	

ACADEMY OF

THE ARTS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3529</u>
W-300 70 3529		CERTIFICATE OF DEATH		
BIRTH NO. <u>70 3529</u>		2. DATE AND HOUR OF DEATH <u>8-31-70 8 P. M.</u>		
1. NAME OF DECEASED (Type or Print) <u>WHITE AUDREY (Audry Mae)</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>USA</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>42 SINAI Hospital</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI Hospital</u>		E. STREET AND NUMBER <u>3705 OVERVIEW Rd.</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-25</u>	9. AGE (In years last birthday) <u>44</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Union Co., N. C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Crockett Lancy</u>		
14. MOTHER'S MAIDEN NAME <u>Eula Thompson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		
16. SOCIAL SECURITY NO. <u>266-40-8712</u>		17. INFORMANT ADDRESS <u>Mrs. Eula Coldwell 17 Warren Rd.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CANCER of COLON with metastasis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>2-30</u> 19 <u>70</u> to <u>3-31</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3-31</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Zita Yorro</u>		23B. DATE SIGNED <u>2-31-70</u>		23C. PHYSICIAN'S NAME (Type) <u>ZITA YORRO</u>
23D. ADDRESS <u>SINAI Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		
24B. DATE <u>4-4-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Morton's Dyett F.H. 1701 Laukers St</u>

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3530

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PATTIE JACOBS (JACOB)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001338 Pennsylvania Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour March 31, 1970 1:20 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1703			
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 8-16-1901		10. AGE (in years lost birthday) 68	E. STREET AND NUMBER 1338 Pennsylvania Avenue
11. BIRTHPLACE (State or foreign country) Norfolk, Virginia		12. CITIZEN OF U.S.A.	13. FATHER'S NAME William Armstrong
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME Lillie Bias
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. 231-07-3770	18. INFORMANT Mrs. Rosie Wilson
		ADDRESS 1338 Penna. Avenue	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/1/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-4-70	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	

ACADEMIC RECORDS

AND CONTENTS

VALLEY PACIFIC CO

1954

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3531</u>	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>LINZA DAVIS</u>			2. DATE AND HOUR OF DEATH <u>April 1, 1970</u> <u>8 30 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90</u> <u>HOUSE IN THE PINES NURSING HOME</u> <u>2525 Belvedere Ave</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1510</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4014 W. Coldspring Lane</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-1891</u>	9. AGE (in years last birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit Co.</u>		11. BIRTHPLACE (State or foreign country) <u>North Thumberland Co., Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>ELI DAVIS</u>		
14. MOTHER'S MAIDEN NAME <u>JULIAN DAVIS</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <u>Mrs. Marie Davis 1459 Mountmoor Court</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>553.81</u> <u>Probable Pulmonary embolus</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Thrombosis</u> <u>4 weeks</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Strangulated Hernia</u> <u>5 weeks</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>March 28, 1970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Strangulated Hernia</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 28th 1970</u> to <u>April 1 1970</u> that (I) (we) last saw the deceased alive on <u>March 31 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alan B Cohen</u> MD			23B. DATE SIGNED <u>4/2/70</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>Alan B Cohen MD</u>			23D. ADDRESS <u>3501 ST Paul ST - 21218</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-4-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Mount Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 3 1970</u>			
25B. NAME OF REGISTRAR <u>26. E. J. J. J. J.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTON & DYETT F.H. 1701 Laurens Street</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-460 70 3532		BALTIMORE CITY HEALTH DEPARTMENT		70 3532	
BIRTH NO.		REG. NO.		70 3532	
1. NAME OF DECEASED (Type or Print) JUNETTA W. COLLIER			2. DATE AND HOUR OF DEATH 4-2-70 10:35 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2712		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 33RD & CALVERT ST BALTO Md 21218			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			E. STREET AND NUMBER 303 E. MELROSE AVE.		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-78	9. AGE (In years lost birthday) 91	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.	
13. FATHER'S NAME Jacob Waltz		14. MOTHER'S MAIDEN NAME Catherine Pope		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 303-348513		17. INFORMANT Walter E. Collier (same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH SCVD (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fx lip (R)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH CONGESTIVE HEART FAILURE IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: FRACURE HIP (R) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION 4-1-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if) (this hospital) attended the deceased from 4-1-70 19 to 4-2-70 19 that (it) (we) last saw the deceased alive on 4-2-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (It) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ricardo Salvilla			23B. DATE SIGNED 4/2/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) RICARDO SALVILLA			23D. ADDRESS UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/6/70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION Baltimore, Md.		24E. CITY, TOWN, OR COUNTY		24F. STATE Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Garber, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
				ADDRESS 1905 York Rd. Balto., Md. 21212	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 3533</u>
T-460 70 3533 BIRTH NO.		70 3533 DATE AND HOUR OF DEATH 4/2/70 at 7:15 A.M.		
1. NAME OF DECEASED (Type or Print) J. CAREY TAYLOR		2. DATE AND HOUR OF DEATH 4/2/70 at 7:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER BROADWAY Rd. Box 321 Lutterville		
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4-22-96 9. AGE (In years last birthday) 73 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. SCHOOL ADMIN. 10B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY SCHOOLS 11. BIRTHPLACE (State or foreign country) (U.S.A.) CARROLL CO. MD 12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN TAYLOR		14. MOTHER'S MAIDEN NAME ROSA WRIGHT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 218-36-1763 17. INFORMANT MRS. HELEN C. TAYLOR (SAME) ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410194-2509 Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes Mellitus + Poor diet		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		II Diabetes Mellitus + Poor diet		
19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from 3/20/70 to 4/2/70 and that (1) (me) last saw the deceased alive on 4/2/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (me) (did) (did not) view the body after death.		
23A. SIGNATURE PB Donovan MD 23B. DATE SIGNED 4/2/70		23C. PHYSICIAN'S NAME (Type) PB Donovan 23D. ADDRESS Sinai Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation 24B. DATE 4/6/70 24C. NAME of CEMETERY or CREMATORY Greenmount		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970 25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. ADDRESS 4905 York Rd. Balto., Md. 21212		

Handwritten notes at the top left, including "SARIN" and "1984".

Handwritten notes at the top right, including "1984" and "X".

Handwritten notes in the middle left, including "1984" and "X".

Handwritten notes in the middle, including "1984" and "X".

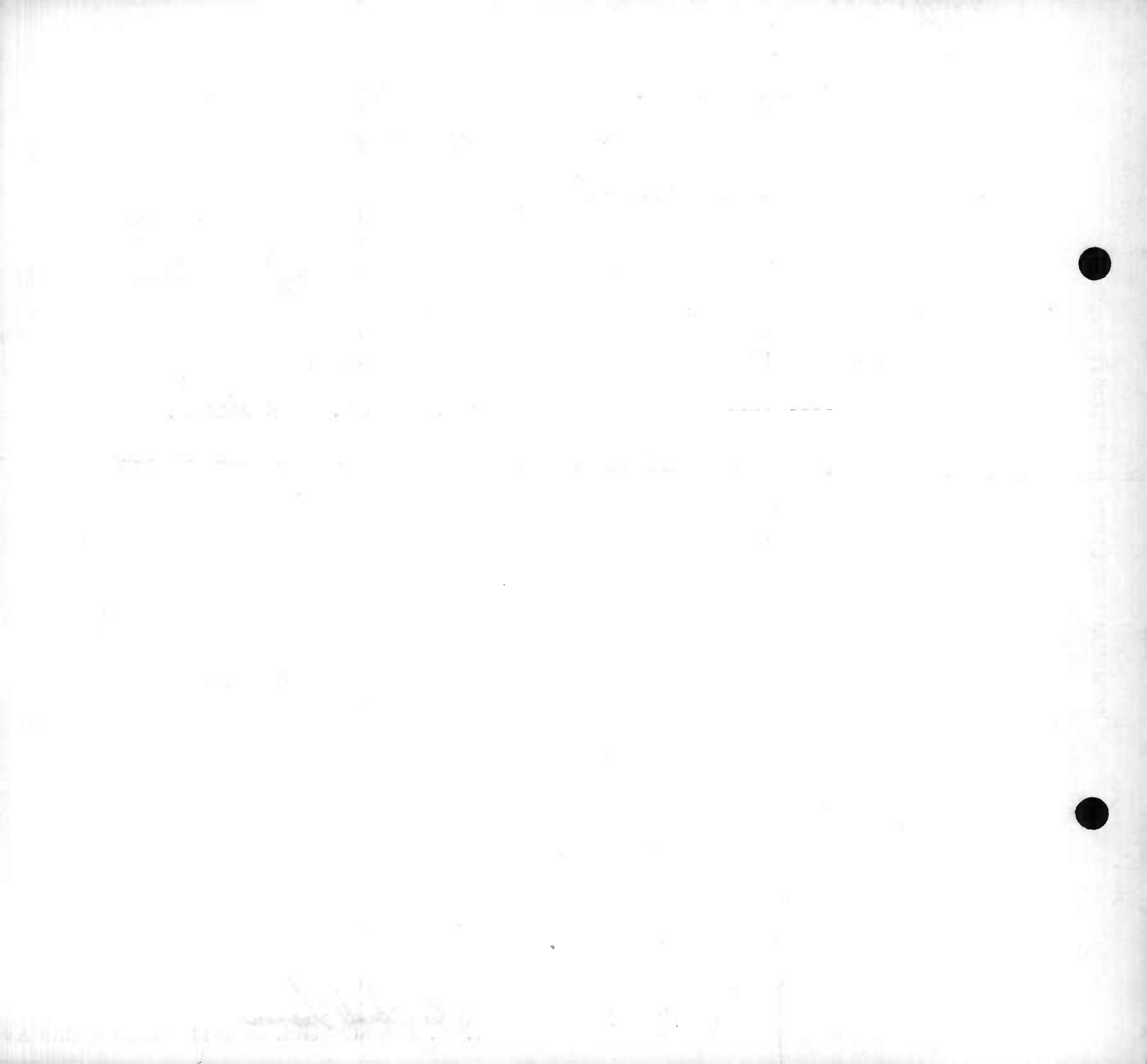
Handwritten notes at the bottom left, including "1984" and "X".

Handwritten notes at the bottom right, including "1984" and "X".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

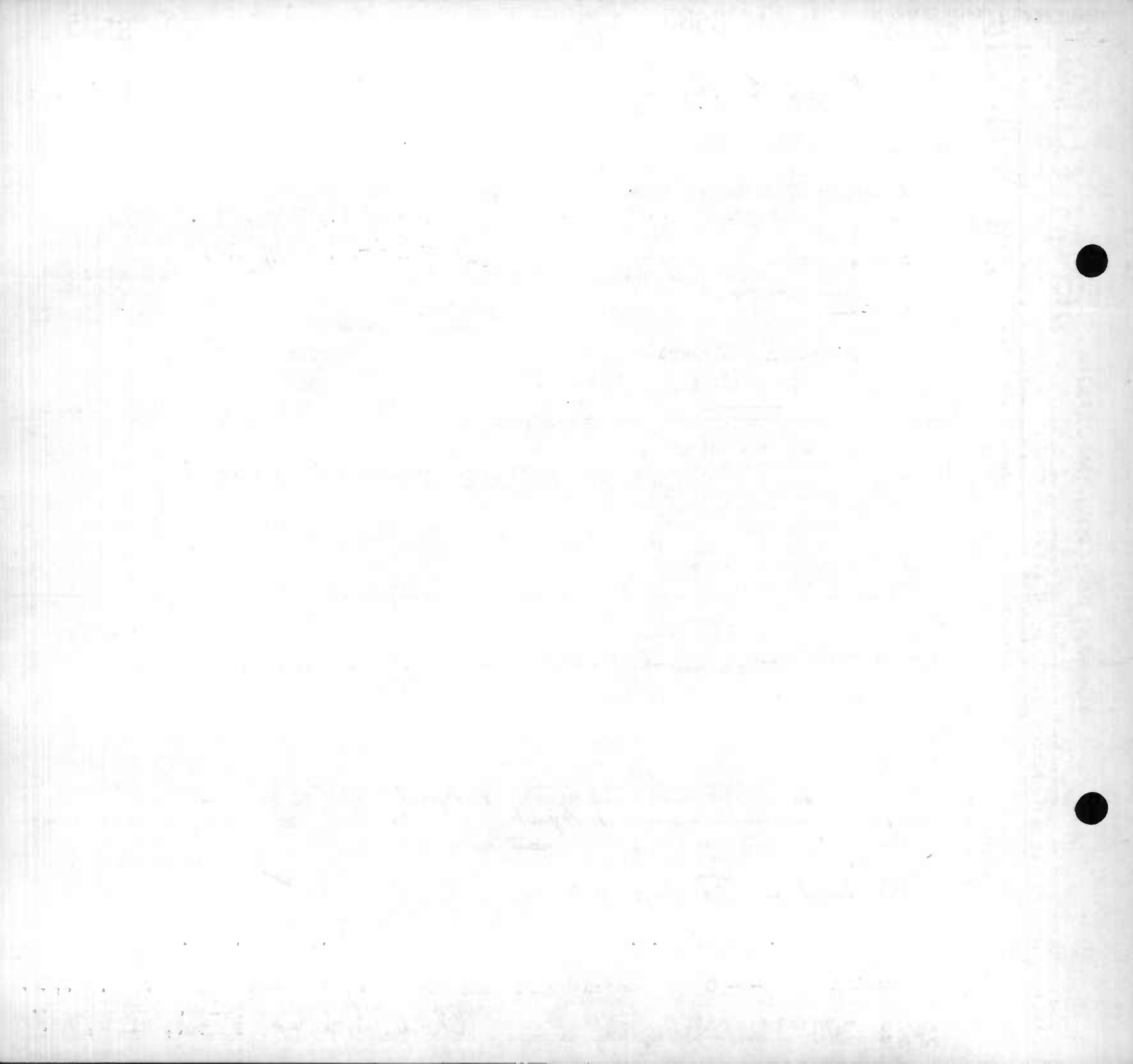
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3534	
B-420 70 3534 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) WALLACE GILBERT BLACK Sr.		2. DATE AND HOUR OF DEATH 11:15 AM 3-29-70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL / BALTIMORE			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2798 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3621 W. Belvedere Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-7-06	9. AGE (in years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Ice Cream		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Gilbert Black		
14. MOTHER'S MAIDEN NAME Zula Goodrich			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 214 20 5422		17. INFORMANT Mrs. Sarah E. Black 3621 W. Belvedere Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLISM			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BILATERAL LOWER LIMB (B) CELLULITIS WITH PHLEBITIS DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PNEUMONIA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 wks.		
19A. DATE OF OPERATION 3-14-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 3-14-70 19__ to 3-29-70 19__ that the (we) last saw the deceased alive on 3-29-70 19__ and that in (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) did not view the body after death.					
23A. SIGNATURE M. Bodenheimer M.D.			23B. DATE SIGNED 3-29-70		23C. PHYSICIAN'S NAME (Type) M. BODENHEIMER M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 2 APR 70		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State) Pikesville, Maryland			25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		
25B. NAME OF REGISTRAR J. E. Lowell Lemmon			25C. FUNERAL DIRECTOR J. E. Lowell Lemmon		
ADDRESS 4611 Park Heights Av					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

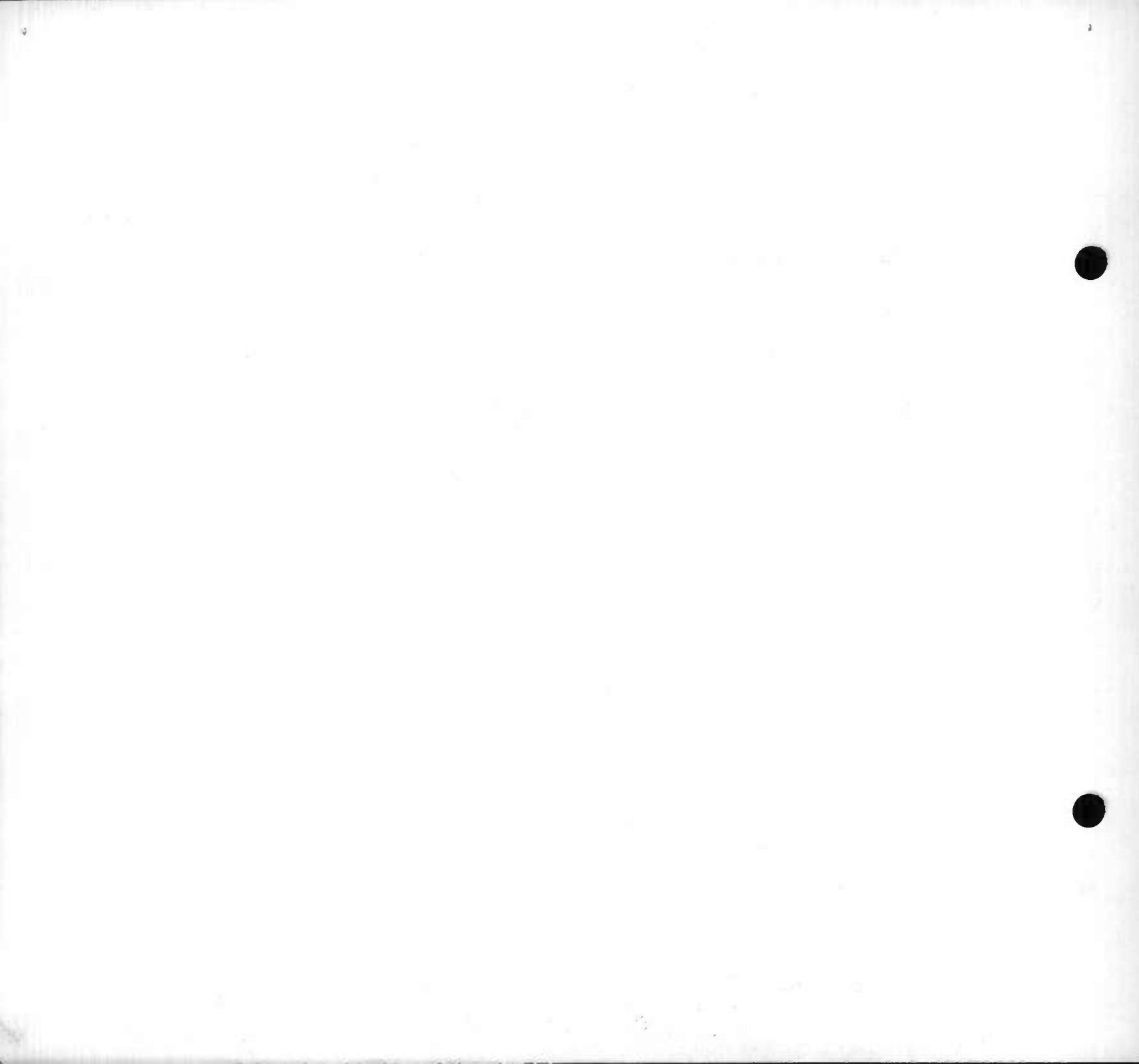
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3535	
<div style="display: flex; justify-content: space-between;"> XXXXXX 45-39-54 XXXXXX 70 3535 </div>					
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) Mary C. Ruley </div> <div> 2. DATE AND HOUR OF DEATH 1 April 70 12:53 A.M. </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2605 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 347 Gusryan St., Balto., Md. 21224		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-95 (9-8-95)	9. AGE (In years last birthday) 74 (74)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Sebastian Lippert			14. MOTHER'S MAIDEN NAME Catherine ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	17. INFORMANT BCH Records: 4940 Eastern Avenue Baltimore, Maryland 21224		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) IMMEDIATE CAUSE Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> <div> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4-10-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 1 April 19 70 to 4-1-70 19 70, that (B) (we) last saw the deceased alive on 1 April 19 70 and that in (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard L. Bishop M.D.				23B. DATE SIGNED 1 April 70	
23C. PHYSICIAN'S NAME (Type) Richard L. Bishop, M.D.		23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave., Balto., Md. 21224			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-4-70	24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery	24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba. Co., Md.		
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR 236 E. Taylor Rd.		25C. FUNERAL DIRECTOR Charles S. Seiler	
ADDRESS 901 S. Conkling St. Balto., 21224, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-636 70 3536		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3536	
1. NAME OF DECEASED (Type or Print) Joseph M. FREDERICK		2. DATE AND HOUR OF DEATH 3-31-70 7:45 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital of Baltimore		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY city CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5503 Rusk Av. - 21215			
5. SEX Male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-28-1884	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Ky	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph M. Frederick		14. MOTHER'S MAIDEN NAME Mary E. Carroll	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-2045		17. INFORMANT Chapt. Wilderson ADDRESS Horseshoe	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9 + 185X (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ca of prostate gland		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: myocardial infarction		(B) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19A. DATE OF OPERATION 1-3-26-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of prostate		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-23 19 70 to 3-31 19 70 that (I) (we) last saw the deceased alive on 3-31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Yes					
23A. SIGNATURE Luis E. Ruyel MD		23B. DATE SIGNED 3-31-70		23C. PHYSICIAN'S NAME (Type) Luis E. Ruyel DEGREE MD	
23D. ADDRESS		23E. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-3-70		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery - Balto, Md.	
24D. LOCATION (City, town, or county) BALTIMORE		24E. LOCATION (City, town, or county) BALTIMORE			
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Amaco Funeral Chapel - 4600 Liberty Hgts	
25D. ADDRESS		25E. ADDRESS			



F-42470

3537

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

3537

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES FLEGLAR FLAGULAR		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour March 30, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour March 30, 1970 M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Washington	
9. DATE OF BIRTH 8-10-95		10. AGE (In years last birthday) 74	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? South Carolina	
13. FATHER'S NAME Jake Flagular		14. MOTHER'S MAIDEN NAME Diane Scott	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		16. KIND OF BUSINESS OR INDUSTRY Railroad	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. 707-05-3765	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. EXAMINER'S NAME (Type): CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 3, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/5/70	
24C. NAME OF CEMETERY or CREMATORY Kingstree, S.C.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 3 1970		25B. NAME OF REGISTRAR Wm C March	
25C. FUNERAL DIRECTOR 928 E. North Ave.		25D. ADDRESS	

1930 March 25

1930 March 25

74

3-10-30

Lake Superior

South Carolina

Class Scott

Halfway

Book

107-05-252

Record of the 1930 March 25

WATER FOR

1930 March 25

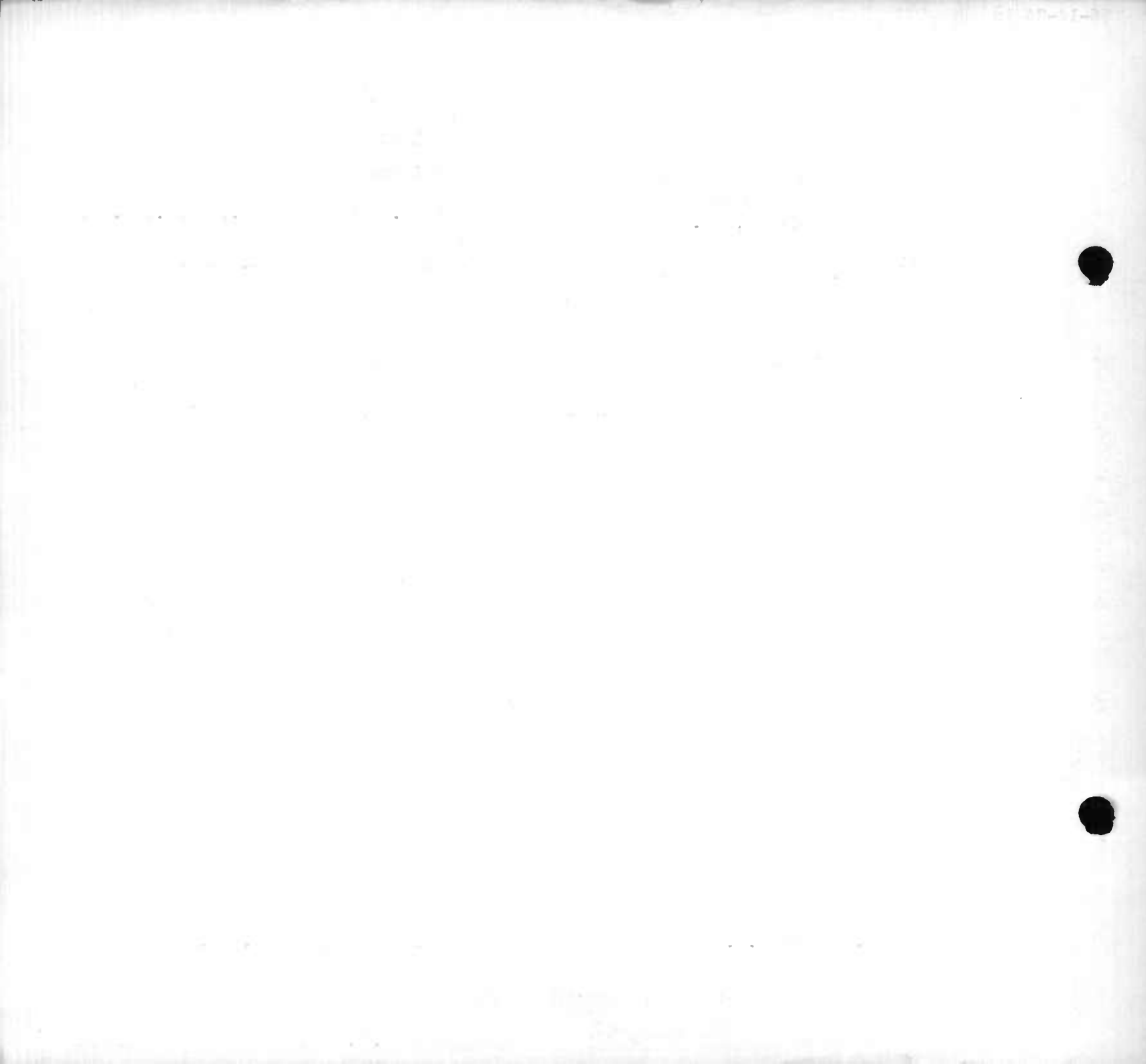
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1930 March 25

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
M-200 70 3538		CERTIFICATE OF DEATH		70 3538	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
James A. Muse		3/29/70 110 ⁴⁰ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Md. 21224		A. STATE Maryland B. COUNTY 604			
5. SEX Male		6. RACE Negro			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 4-20-03			
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) 66			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY			
		11. BIRTHPLACE (State or foreign country) Virginia			
13. FATHER'S NAME William Muse		14. MOTHER'S MAIDEN NAME Mary Washington			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-10-6479			
17. INFORMANT 4940 Eastern Avenue Baltimore, Md. 21224 BCH Records: Hilda Tucker* same		12. CITIZEN OF WHAT COUNTRY? United States			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 120.31 respiratory arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. squamous cell carcinomatosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 1/28/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy of 4 th rib			
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22. I certify that (I) (this hospital) attended the deceased from 1/15 1970 to 3/29 1970 that (I) (we) last saw the deceased alive on 3/29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE C. Krush		23B. DATE SIGNED 3/29/70	
23C. PHYSICIAN'S NAME (Type) C. Krush, M.D.		23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave., Balto., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-3-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 3 1970		24F. NAME OF REGISTRAR Robert E. Jarber, M.D.	
24G. FUNERAL DIRECTOR V. Bailey		24H. ADDRESS Kelson F.H. 1348 Calhoun Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8-530 70 3539		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3539	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Smith, Augusta Virginia		2. DATE AND HOUR OF DEATH 3-31-70 12:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1403			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Divison Street Baltimore, Maryland 21217		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 533 Presstman St.			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-22	9. AGE (In years last birthday) 47	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Short Order Cook		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Marcus Smith		14. MOTHER'S MAIDEN NAME Sadie Kelly	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-24-8363		17. INFORMANT M's Saddle Smith-Mother	
18. 43691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF: (B) Malnutrition and Dehydration DUE TO, OR AS A CONSEQUENCE OF: (C) Uremia		19. DATE OF OPERATION 5		20A. AUTOPSY? (Yes or No) Yes	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-19-70 19 to 3-31-70 19 that (I) (we) last saw the deceased alive on 3-31-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymundo R. Corpuz, M.D.		23B. DATE SIGNED March 31, 1970		23C. PHYSICIAN'S NAME (Type) Raymundo R. Corpuz, M.D.	
23D. ADDRESS 1514 Divison Street Baltimore, Md.		23E. FUNERAL DIRECTOR V. Bailey		23F. ADDRESS Kelson F.H. 1348 Calhoun Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-3-70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 3 1970		24F. NAME OF REGISTRAR James E. Smith, M.D.	



B-260 70 3540 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 3540

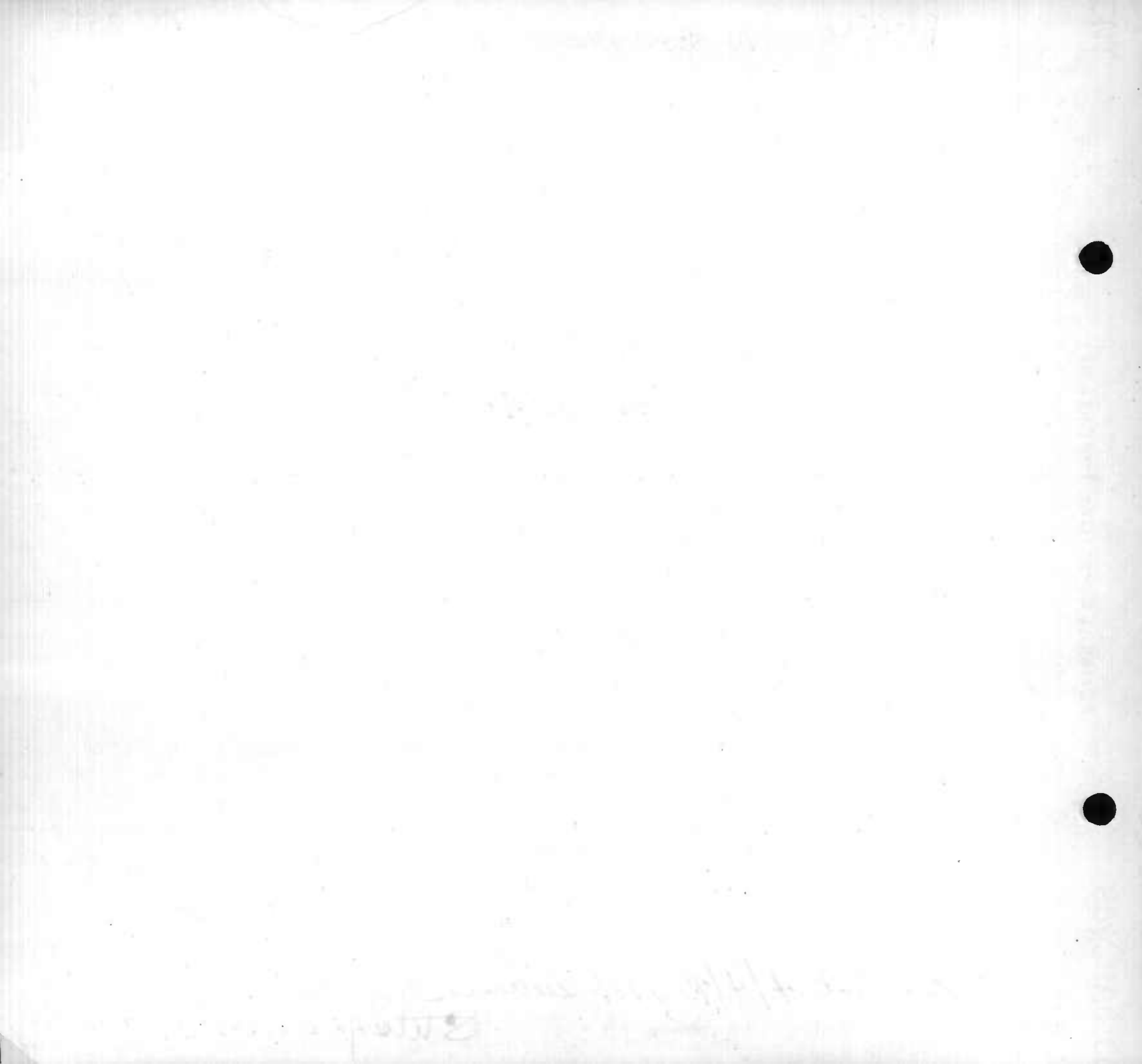
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Allen WILLIAM BOOKER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> April 1, 1970 6:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour April 1, 1970 6:30 P.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2001	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1-10-48		10. AGE (in years last birthday) 22	11. BIRTHPLACE (State or foreign country) Md.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Floyd Booker		E. STREET AND NUMBER 1904 W. Saratoga Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) attendant		14B. KIND OF BUSINESS OR INDUSTRY service station		15. MOTHER'S MAIDEN NAME Laura Sutton	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 214-50-1660		18. INFORMANT ADDRESS Floyd & Laura Booker same	
19. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E81511					
(A) IMMEDIATE CAUSE Cerebro-cranial injuries DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 6		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore and Exeter Streets	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 3-31-70 2:00 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Passenger in auto-fixed object collision	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 2, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-6-70		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 3 1970			
25B. NAME OF REGISTRAR Robert C. Taylor, M.D.		25C. FUNERAL DIRECTOR V Bailey ADDRESS Kelson F.H. 1348 Calhoun St.			

WALL CY-PAPER CO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

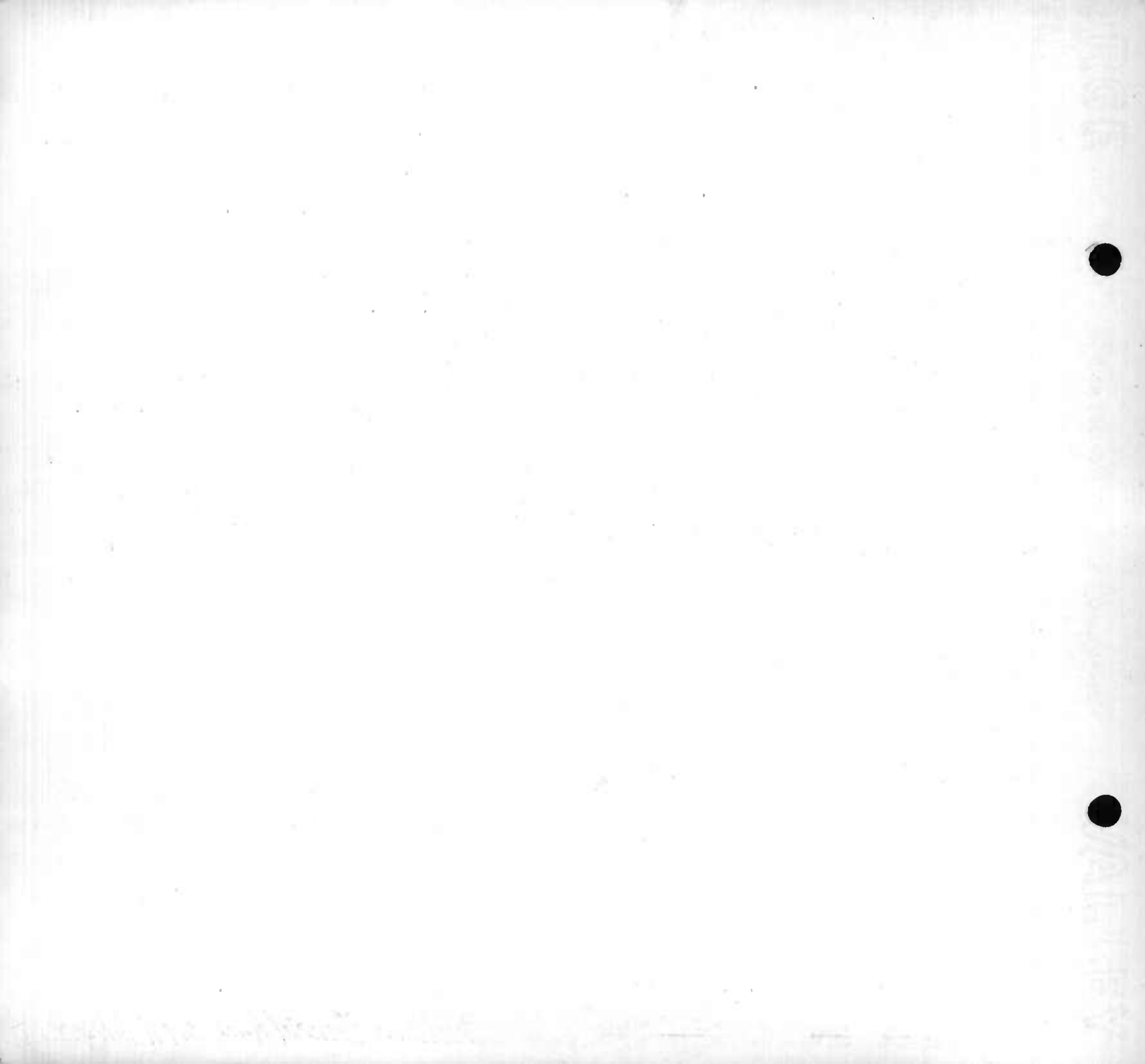
Baltimore City Health Department				REG. NO.	
B-650		70 3541		70 3541	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CLAUDE BROWN		3-29-70 2:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
SOUTH BALTO. GEN. HOSP.		MARYLAND, U.S.A. 2562			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2534 JOSEPH AVE			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-1-10	59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE				NORTH CAROLINA U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
ABNER (DEC.)			ALICE BROWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		243-07-0464		HESTER BROWN - WIFE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
410.9 I		ACUTE MYOCARDIAL INFARCTION			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ARTERIOSCLEROTIC DUE TO, OR AS A CONSEQUENCE OF:			
		(C) CARDIOVASCULAR DIS.			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3-26 19 70 to 3-29 19 70, that (I) (we) lost saw the deceased alive on 3-29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Lilia C. Baldonado				3-29-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
LILIA C. BALDONADO MD		53 Gt BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial 4/4/70 Mt Auburn Cem Baltimore MD		4/4/70		Mt Auburn Cem Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 3 1970		Robert E. Taylor		Shirley Wilson 4913 W. Bk	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
B-400 70 3542				70 3542	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Mary R. Bailey			2. DATE AND HOUR OF DEATH April 1, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1703		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 725 George St. Apt. 4G			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 725 George St. Apt. 4G		
5. SEX Female	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1906	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Jacob Henson			14. MOTHER'S MAIDEN NAME Lucy Henson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Joseph Bailey 725 George St. Apt. 4G	
18. 412.214-174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Artery Disease			(B) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1967 to 1969 , that (I) (we) lost saw the deceased alive on Mar 25 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rayston B. Scott				23B. DATE SIGNED April 3, 20	
23C. PHYSICIAN'S NAME (Type) Rayston B. Scott				23D. ADDRESS 18014 Beekman St. Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 4, 1970		24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park	
24D. LOCATION Laurel Md.		24E. DATE REC'D BY HEALTH DEPT. APR 3 1970			
25A. NAME OF REGISTRAR James E. Taylor, M.D.		25B. NAME OF REGISTRAR		25C. FUNERAL HOME Williams Funeral Home 3197 E. Howard St.	
25D. ADDRESS		25E. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

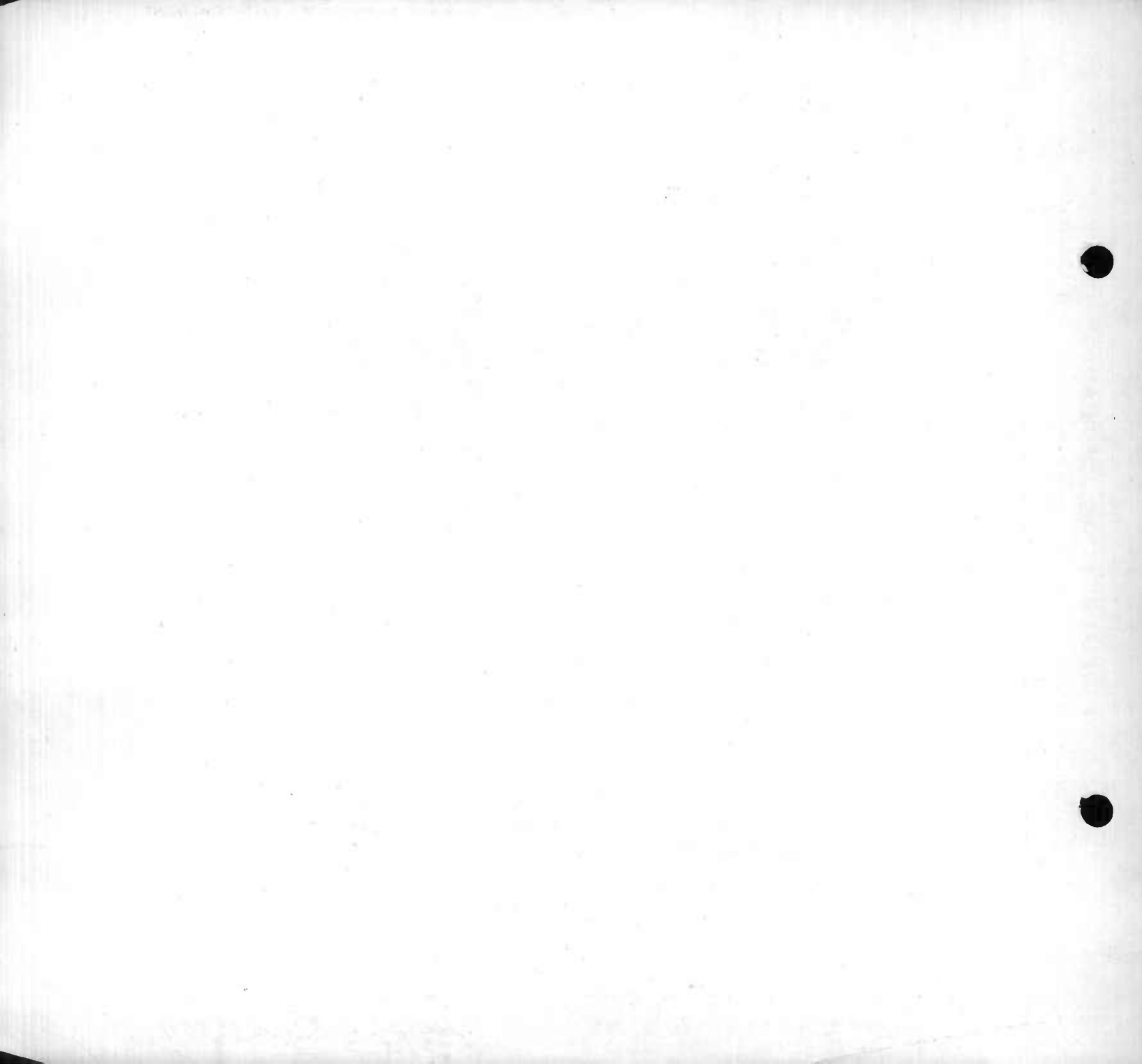
BIRTH NO. T-520 70 3543				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3543	
1. NAME OF DECEASED (Type or Print) Thomas, Dora				2. DATE AND HOUR OF DEATH 3-26-70 9:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Provident Hospital 1514 Divison Street Baltimore, Maryland 21217		A. STATE Maryland		B. COUNTY 2506	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3420 Childs Court			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-88	9. AGE (in years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME				
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Alice Bloodsaw				
18. ADDRESS 3314 Remley St.			19. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 402X I			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive heart disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) CVA DUE TO, OR AS A CONSEQUENCE OF:				
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-23-70 19 to 3-26-70 19 that (I) (we) last saw the deceased alive on 3-26-70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED March 27, 1970		23C. PHYSICIAN'S NAME (Type) [Signature]	
23D. ADDRESS 1514 Divison Street Baltimore, Md.				24A. BURIAL CREMATION, REMOVAL (Specify) 4/2/70			
24B. DATE 4/2/70				24C. NAME OF CEMETERY or CREMATORY Catholic Memorial Park			
24D. LOCATION (City, town, or county) (State) Baltimore				25A. DATE REC'D BY HEALTH DEPT. APR 3 1970			
25B. NAME OF REGISTRAR [Signature]				25C. FUNERAL DIRECTOR [Signature]			
25D. ADDRESS 1701 N Bond St				25E. DATE 4/2/70			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3544
0-520 70 3544		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Fannie B. Owens		2. DATE AND HOUR OF DEATH March 28 1970 4:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1304		
FULL NAME OF HOSPITAL OR INSTITUTION 3300 Cuckentoroly Terrace		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female 6. RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/31/1900 9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.
13. FATHER'S NAME William Dixon		14. MOTHER'S MAIDEN NAME Holla Dixon		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary Hawkins 3300 Cuckentoroly
18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several Hrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic Asthma Unknown		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6-1-1969 to 3-28-1970 , that (I) (we) last saw the deceased alive on 3-24-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Richard H. Hunt		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3-31-70
23C. PHYSICIAN'S NAME (Type) Richard H. Hunt		23D. ADDRESS 1607 W. Mulberry St. Balto. Md 21223		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/2/70	24C. NAME OF CEMETERY or CREMATORY Arboretum Mem. Park		24D. LOCATION (City, town, or county) (State) Arboretum Md.
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Joseph L. Rues
				ADDRESS 2222 W. North Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
H-400 70 3545					CERTIFICATE OF DEATH					
REG. NO. 70 3545										
1. NAME OF DECEASED (Type or Print) HALL, Robert SPENCER					2. DATE AND HOUR OF DEATH 3/29/70 5²⁵ A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MARYLAND HOSPITAL					A. STATE MD B. COUNTY Worcester Co. 73-00					
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION					C. CITY OR TOWN OCEAN CITY D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER 205 DOLPHIN ST.										
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-21	9. AGE (In years last birthday) 48	10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT			10B. KIND OF BUSINESS OR INDUSTRY RETAIL BUS.		11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME HERBERT HENRY HALL					14. MOTHER'S MAIDEN NAME BLANCHE PRESCOTT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES. WWII - KOREA.			16. SOCIAL SECURITY NO. 577-10-7883		17. INFORMANT MRS. R. S. HALL, OCEAN CITY MD				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HODGKINS DISEASE (AGAMMA GLOBULINEMIA)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 months					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).										
19A. DATE OF OPERATION No.			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from February 19 69 to March 29 19 70 that (I) (we) last saw the deceased alive on March 29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE M. S. Wizenberg					23B. DATE SIGNED 3-29-70			23C. PHYSICIAN'S NAME (Type) M. S. WIZENBERG MD		
23D. ADDRESS UNIV. OF MD HOSPITAL										
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 3/31/70			24C. NAME of CEMETERY or CREMATORY ST. PAUL'S CHURCHWARD BERRY			24D. LOCATION (City, town, or county) (State) Wor MD	
25A. DATE RECEIVED BY HEALTH DEPT. APR 6 1970			25B. NAME OF REGISTRAR Anna B. Bumbage			25C. FUNERAL DIRECTOR Anna B. Bumbage				
						ADDRESS Berlin Md				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-552		70 3546		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3546	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) RENNINGER-LLOYD H.			
2. DATE AND HOUR OF DEATH 4-2-1970 2:40 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 104				5. SEX M 6. RACE W			
C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
E. STREET AND NUMBER 2601 FAIT AVE. #21224				8. DATE OF BIRTH 03-09-13 9. AGE (in years last birthday) 56			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MASON				10B. KIND OF BUSINESS OR INDUSTRY BETH STEEL CO.			
11. BIRTHPLACE (State or foreign country) PENNA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME (MEHLON) MAYLAND RENNINGER				14. MOTHER'S MAIDEN NAME MARY HOFFMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 184-07-9571			
17. INFORMANT STELLA RENNINGER-2601 FAIT AVE.				ADDRESS			
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary occlusion & pulmonary embolism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Thrombi, Pericardial app. loose heart (B) DUE TO, OR AS A CONSEQUENCE OF: Severe pulmonary emphysema (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-2-1970 to 4-2-1970 that (I) (we) last saw the deceased alive on 4-2-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Isabel M. Torres, M.D.				23B. DATE SIGNED April 3, 1970		23C. PHYSICIAN'S NAME (Type) DR. TORRES	
23D. ADDRESS 441 S. ELLWOOD AVE. BALTO. Md.				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/4/70		24C. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR George A. Weber		25C. FUNERAL DIRECTOR GEORGE A. WEBER-705 S. Ann ST.		ADDRESS #21231	

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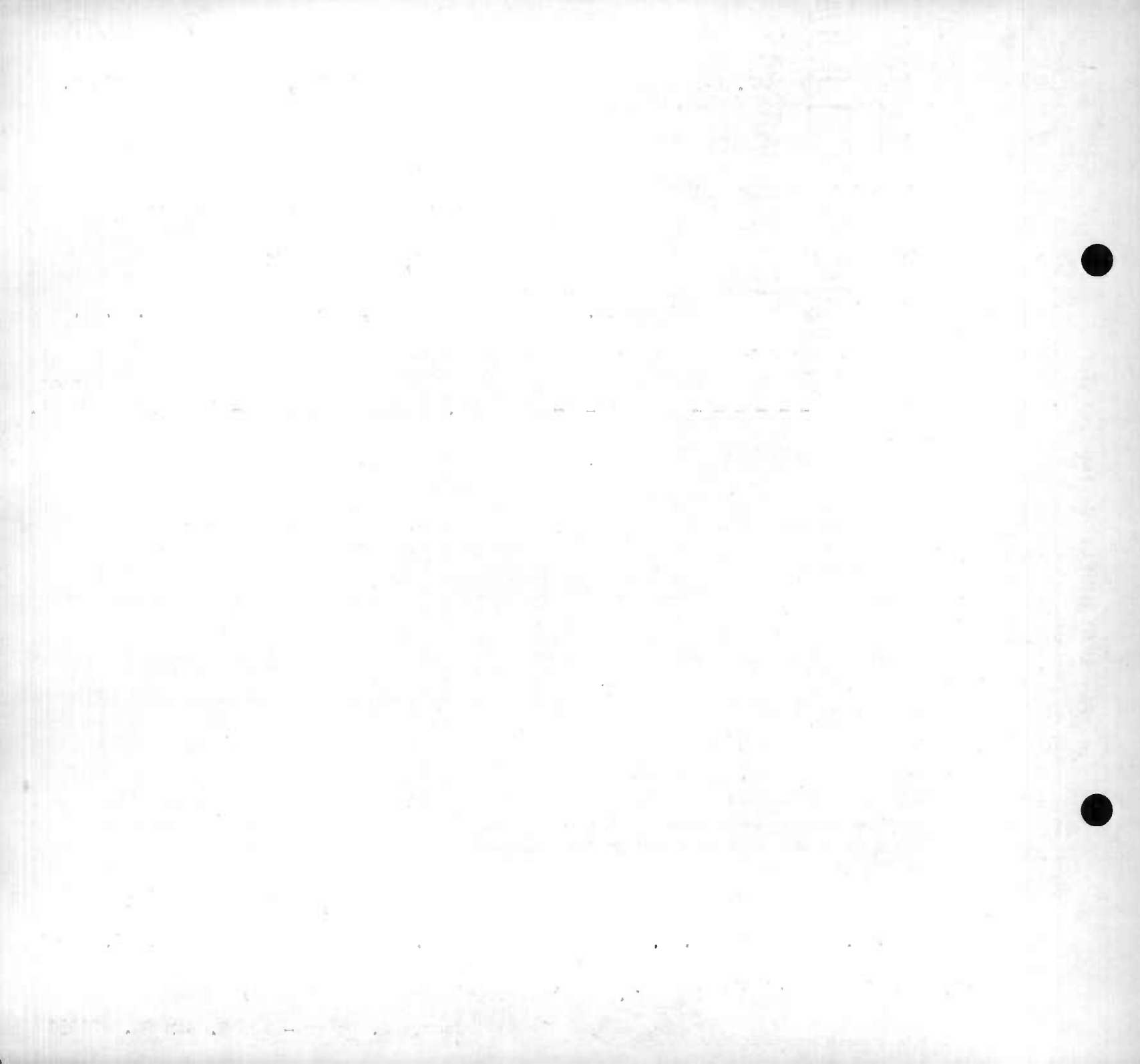
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3547	
BIRTH NO. B-252 70 3547				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Edward J. Bochenek			2. DATE AND HOUR OF DEATH April 4th, 1970 9:45 a.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1923 Aliceanna Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 203		
5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH June 24, 1908 9. AGE (In years lost birthday) 61		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roll Grinder			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		
10B. KIND OF BUSINESS OR INDUSTRY Revere Copper and Brass Co.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Joseph Bochenek			14. MOTHER'S MAIDEN NAME Mary		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-03-5308		
17. INFORMANT Mrs. Madeline Bochenek - 1923 Aliceanna St.			ADDRESS #21231		
18. 4122 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL HEMORRHAGE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIO SCLEROTIC HYPERTENSIVE DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: R.T. HEMIPLEGIA (C) 2 YRS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-4-70 2-2-70		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> None		21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (the hospital) attended the deceased from Feb 2 19 70 to April 4 19 70 , that (I) (we) last saw the deceased alive on April 3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.					
23A. SIGNATURE E. A. Schimunek				23B. DATE SIGNED 4-4-70	
23C. PHYSICIAN'S NAME (Type) E. A. Schimunek M. D.				23D. ADDRESS 842 S. East Avenue Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/7/70		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 6 1970			
25A. NAME OF REGISTRAR Robert E. Taylor M.D.		25B. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

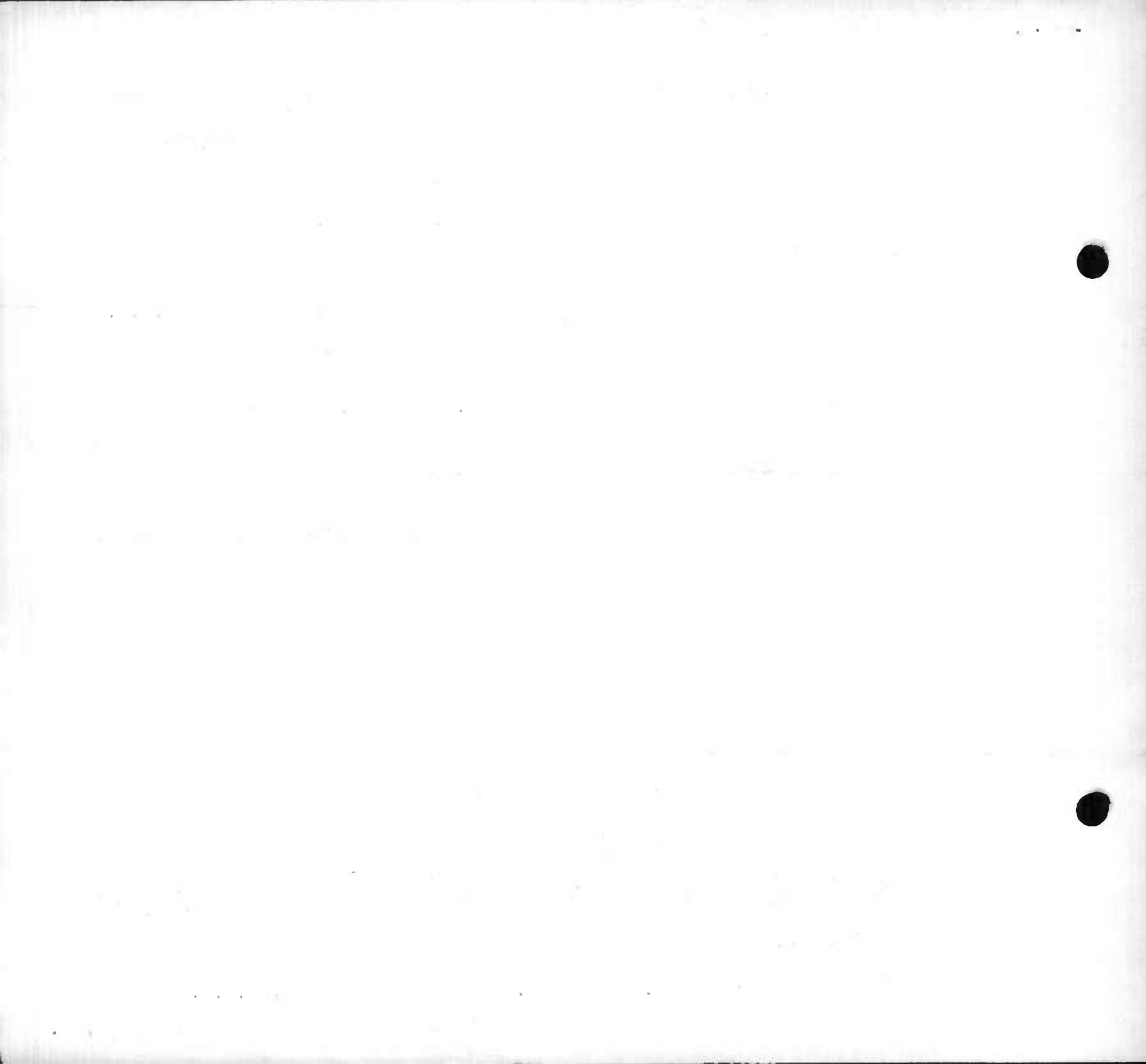
VS 150-RPV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

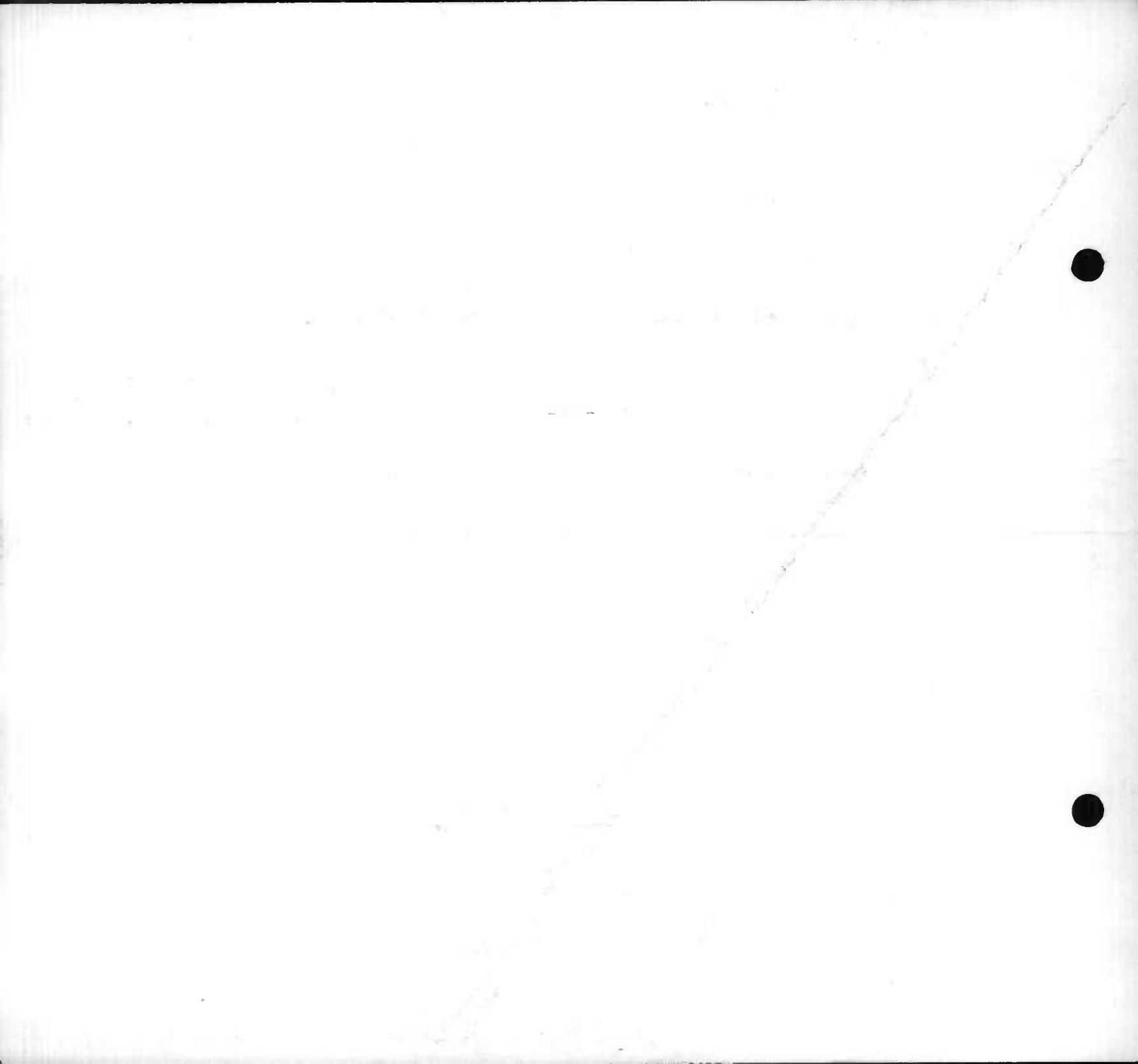
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3549	
BIRTH NO. C-420 70 3549 64-13271		2. DATE AND HOUR OF DEATH 3/31/70 10:00 P.M.	
1. NAME OF DECEASED (Type or Print) CHALK, Susan Paige		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY Anne Arundle	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital		C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/11/64 9. AGE (In years last birthday) 5	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
10B. KIND OF BUSINESS OR INDUSTRY None		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Chalk		14. MOTHER'S MAIDEN NAME Joan Brandau	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. XXXXXXXX	
17. INFORMANT Mr. Howard R. Chalk - Same as #4		ADDRESS	
18. 347.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIO-RESP ARREST DUE TO, OR AS A CONSEQUENCE OF: REYE'S SYNDROME (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 44 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 3/30		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/30 19 70 to 3/31 19 70 that (I) (we) last saw the deceased alive on 3/31/70 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Wm G. Bartholome, M.D.		23B. DATE SIGNED 3/31/70.	
23C. PHYSICIAN'S NAME (Type) William G. Bartholome, M.D.		23D. ADDRESS The Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/31/70	
24C. NAME of CEMETERY or CREMATORY Mt. Carmel Ch. Cemetery		24D. LOCATION (City, town, or county) (State) Pasadena, R.F.O. Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert W. Ware	
25C. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

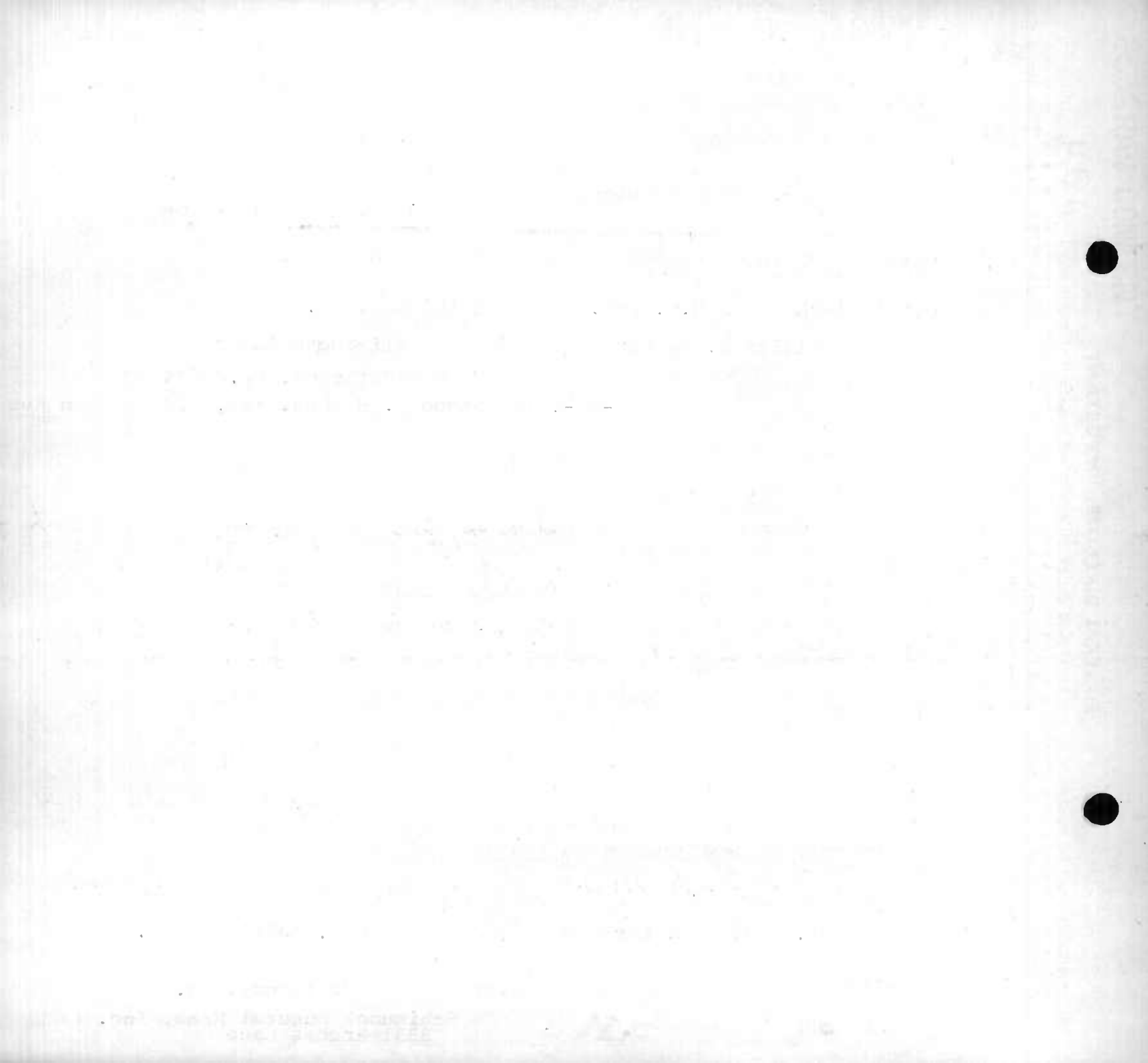
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
S-366		70 3550		70 3550	
1. NAME OF DECEASED (Type or Print) STROHRMANN-BERTHA			2. DATE AND HOUR OF DEATH 4-1-70 8:40AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL			A. STATE MD		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY 2101		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-07-85	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Clerical		10B. KIND OF BUSINESS OR INDUSTRY Ward Baking Co		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME GEORGE W. STROHRMANN			14. MOTHER'S MAIDEN NAME SCHMIDT, ELIZABETH		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 216-05-0373		
			17. INFORMANT Julian Ahrens, nephew, 101 W. Monument		
			ADDRESS 21201		
18. 433.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CVA (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE (B) Cerebral Thrombosis (C) Arteriosclerosis generalized			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-20 19 70 to 4-1- 19 70 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Julio Gutierrez MD.			23B. DATE SIGNED 4-1-70		
23C. PHYSICIAN'S NAME (Type) JULIO GUTIERREZ MD.			23D. ADDRESS MARYLAND GENERAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/4/70		24C. NAME of CEMETERY or CREMATORY Western Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor MD.		25C. FUNERAL DIRECTOR Schmitt's Funeral Home 3231 Archers Ln.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3551	
<div style="font-size: 1.5em; font-weight: bold;">4-220</div> <div style="font-size: 1.5em; font-weight: bold;">70 3551</div>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
<div style="font-size: 1.2em; font-weight: bold;">GEORGE WILLIAM HUGHES</div>		<div style="font-size: 1.2em; font-weight: bold;">April 1, 1970</div> <div style="font-size: 1.2em; font-weight: bold;">2 p.</div>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. SEX		6. RACE	
<div style="font-size: 1.2em; font-weight: bold;">Md. 21224</div>		<div style="font-size: 1.2em; font-weight: bold;">male</div>		<div style="font-size: 1.2em; font-weight: bold;">white</div>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
<div style="font-size: 1.2em; font-weight: bold;">WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div style="font-size: 1.2em; font-weight: bold;">7/12/1878</div>		<div style="font-size: 1.2em; font-weight: bold;">91</div>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<div style="font-size: 1.2em; font-weight: bold;">Postal Clerk</div>		<div style="font-size: 1.2em; font-weight: bold;">U.S. Govt.</div>		<div style="font-size: 1.2em; font-weight: bold;">Baltimore, Md.</div>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
		<div style="font-size: 1.2em; font-weight: bold;">William J. Hughes</div>		<div style="font-size: 1.2em; font-weight: bold;">Elizabeth Fuchs</div>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		<div style="font-size: 1.2em; font-weight: bold;">220-44-6311</div>		<div style="font-size: 1.2em; font-weight: bold;">Bethesda, Md. 20034</div>	
				<div style="font-size: 1.2em; font-weight: bold;">Jacob W. Hughes, son, 5804 Johnson Ave</div>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<div style="font-size: 1.2em; font-weight: bold;">I</div>		<div style="font-size: 1.2em; font-weight: bold;">myocardial infarction</div>		<div style="font-size: 1.2em; font-weight: bold;">?</div>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
<div style="font-size: 1.2em; font-weight: bold;">ANTECEDENT CAUSES</div>		(B) DUE TO, OR AS A CONSEQUENCE OF:		<div style="font-size: 1.2em; font-weight: bold;">1 month</div>	
<div style="font-size: 1.2em; font-weight: bold;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div>		(C) <div style="font-size: 1.2em; font-weight: bold;">ACVD</div>		<div style="font-size: 1.2em; font-weight: bold;">?</div>	
<div style="font-size: 1.2em; font-weight: bold;">II</div>		<div style="font-size: 1.2em; font-weight: bold;">congestive heart failure</div>		<div style="font-size: 1.2em; font-weight: bold;">3-4 yrs.</div>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <div style="font-size: 1.2em; font-weight: bold;">June 1964</div> to <div style="font-size: 1.2em; font-weight: bold;">mar 11 1970</div> that (I) (we) last saw the deceased alive on <div style="font-size: 1.2em; font-weight: bold;">mar 11 1970</div> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
<div style="font-size: 1.2em; font-weight: bold;">Dr. Burton V. Look</div>		<div style="font-size: 1.2em; font-weight: bold;">4/3/70</div>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<div style="font-size: 1.2em; font-weight: bold;">Dr. Burton V. Look</div>		<div style="font-size: 1.2em; font-weight: bold;">2936 E. Baltimore St.</div>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<div style="font-size: 1.2em; font-weight: bold;">Burial</div>		<div style="font-size: 1.2em; font-weight: bold;">4/3/70</div>		<div style="font-size: 1.2em; font-weight: bold;">Oak Lawn Cemetery</div>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
<div style="font-size: 1.2em; font-weight: bold;">Baltimore, Md.</div>		<div style="font-size: 1.2em; font-weight: bold;">APR 6 1970</div>		<div style="font-size: 1.2em; font-weight: bold;">Schimunek Funeral Home, Inc.</div>	
				<div style="font-size: 1.2em; font-weight: bold;">3331 Brehms Lane</div>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
REG. NO. 70 3552									
BIRTH NO. D-360 70 3552									
1. NAME OF DECEASED (Type or Print) LEWIS G. DEDDER, Sr.					2. DATE AND HOUR OF DEATH April 2, 1970 9:20 A.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 136 South Boulden Street 21224				
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-1-37 '98		9. AGE (In years last birthday) 32 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meat Brine Maker Esskay					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William Dedder					14. MOTHER'S MAIDEN NAME Carolina A				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 213-03-9152		17. INFORMANT BCH: Records Baltimore, Maryland 21224		
18. 190 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease or injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
CAUSE OF DEATH IMMEDIATE CAUSE SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF: MENINGITIS CA @ ORBIT FRACTURE @ Hip.									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK. 1 WEEK. YEARS 2 WEEKS.									
19A. DATE OF OPERATION 3/23/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ex @ Hip			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 0		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 3/17/70 19 to 4/2/70 19 that (I) (we) last saw the deceased alive on 4/2/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Enrique Castro					23B. DATE SIGNED April 2, 1970			23C. PHYSICIAN'S NAME (Type) ENRIQUE CASTRO, MD	
23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland BALTIMORE CITY HOSPITALS 21224					24A. BURIAL CREMATION, REMOVAL (Specify) Burial				
24B. DATE 4/5/70		24C. NAME of CEMETERY or CREMATORY Riverview Cemetery			24D. LOCATION (City, town, or county) (State) Charlottesville, Va.				
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR John A. Moran, Inc.			25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.				



W-222 70 3553		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 3553	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) FRANK WOJCHICHOWSKI				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 4 2 70 Hour 6:40 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Balto. General Hospital				3. DATE PRONOUNCED DEAD Month Day Year April 2, 1970 Hour 6:40 a.m.			
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Anne Arundel				C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH July 24, 1926		10. AGE (In years lost birthday) 43		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman				15. MOTHER'S MAIDEN NAME Julia Bongart			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes WW II				17. SOCIAL SECURITY NO. 220 12 7261		18. INFORMANT ADDRESS Mrs. Jeanette Wojciechowski	
19. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Fatty metamorphosis of the liver DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/6/70		24C. NAME OF CEMETERY OR CREMATORY Holy Cross	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				24E. DATE REC'D BY HEALTH DEPT. APR 6 1970			
25A. NAME OF REGISTRAR George J. Gonce				25B. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hgy. Baltimore, Md. 21225			

ACADEMY HONOR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-330 70 3554		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X 70 3554 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SMITH, ISABELLA S.		APRIL 2nd 1970 9:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND BALTIMORE CO. 5300	
UNION MEMORIAL HOSPITAL 44				C. CITY OR TOWN D. INSIDE CITY LIMITS? BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2014 GREENGAGE ROAD	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE		05-24-12	57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSE WIFE				MARYLAND	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
WILLIAM MAGRUTHER			U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				HOWARD S. SMITH SAME AS ABOVE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I 492X				1	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 1st 1970 to April 2nd 1970 that (I) (we) last saw the deceased alive on April 2nd 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. CABRERA V. M.D. DEGREE				APRIL 2nd 1970	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. CABRERA V. M.D. DEGREE		UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4-7-70		LONDON PARK CEM	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 6 1970		J. E. GIBBS M.D.		BURGER FUNERAL HOME 3631 Falls Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

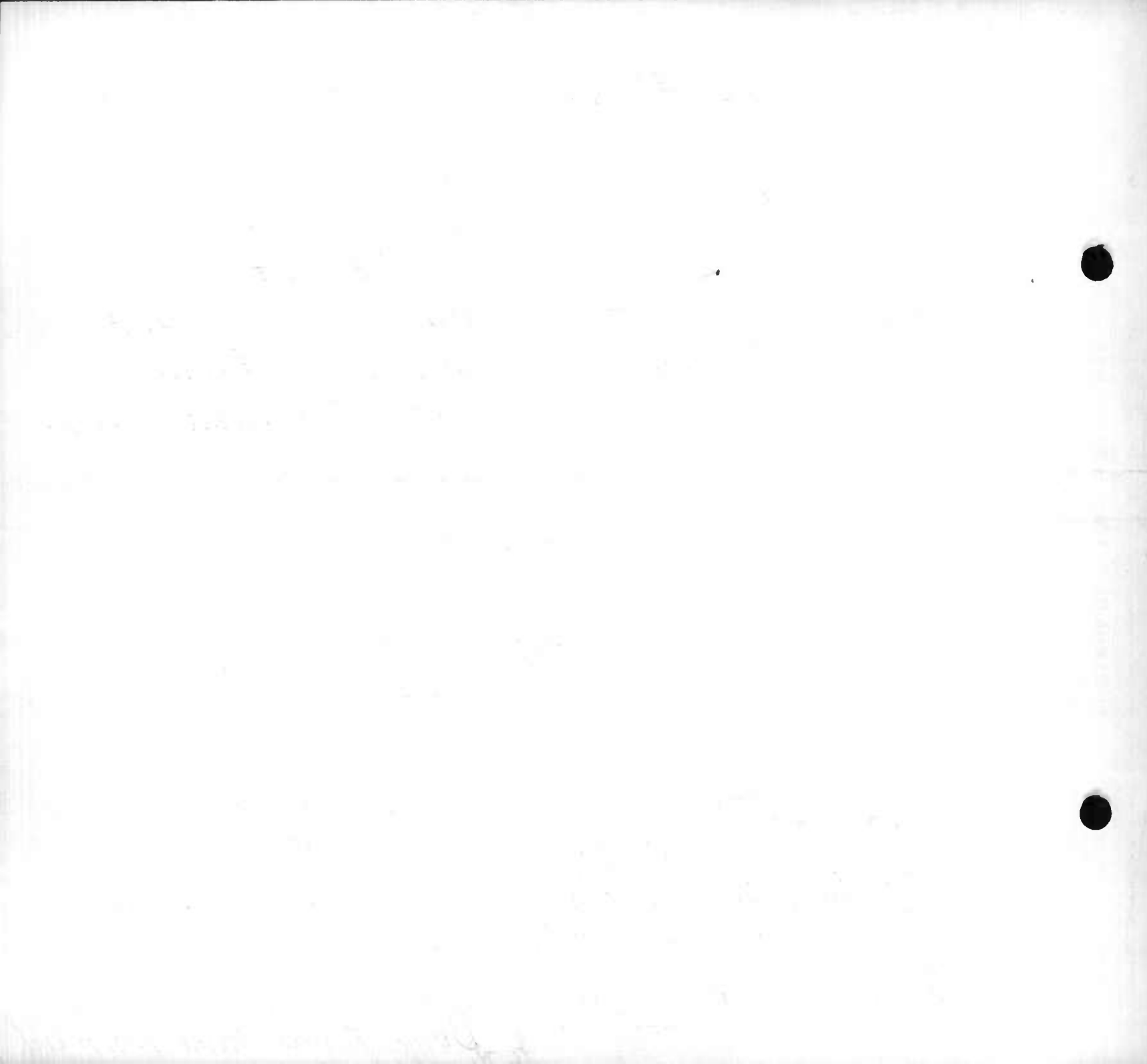
BALTIMORE CITY HEALTH DEPARTMENT				X	
BIRTH NO.		70 3555		REG. NO. 70 3555	
1. NAME OF DECEASED (Type or Print) <u>John A Johnson</u>			2. DATE AND HOUR OF DEATH <u>4/1/70</u> <u>16:42</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital Inc.</u>			A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Balto</u>		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>Belvedere Ave. at Greenspring</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/20/1890</u>	9. AGE (in years last birthday) <u>79</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cheffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Moving</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>217 09 2210</u>		17. INFORMANT <u>Alice E Johnson</u>
			ADDRESS <u>3508 Hickory Ave</u>		
18. I <u>162.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Lung</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Histoplasmosis both lungs</u>		<u>years</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> 19 <u>70</u> to <u>4/1/1</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/1/70</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Uferl MD.</u>			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>Carlos R. Perel</u>			23D. ADDRESS <u>Sinai Hospital of Balto.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-4-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park</u>	
24D. LOCATION <u>Woodlawn Balto Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>APR 6 1970</u>		24F. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
24G. FUNERAL DIRECTOR <u>Burger Funeral Home Balto Md</u>		24H. ADDRESS			

2809 Garnet Rd - last address
Called funeral home.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

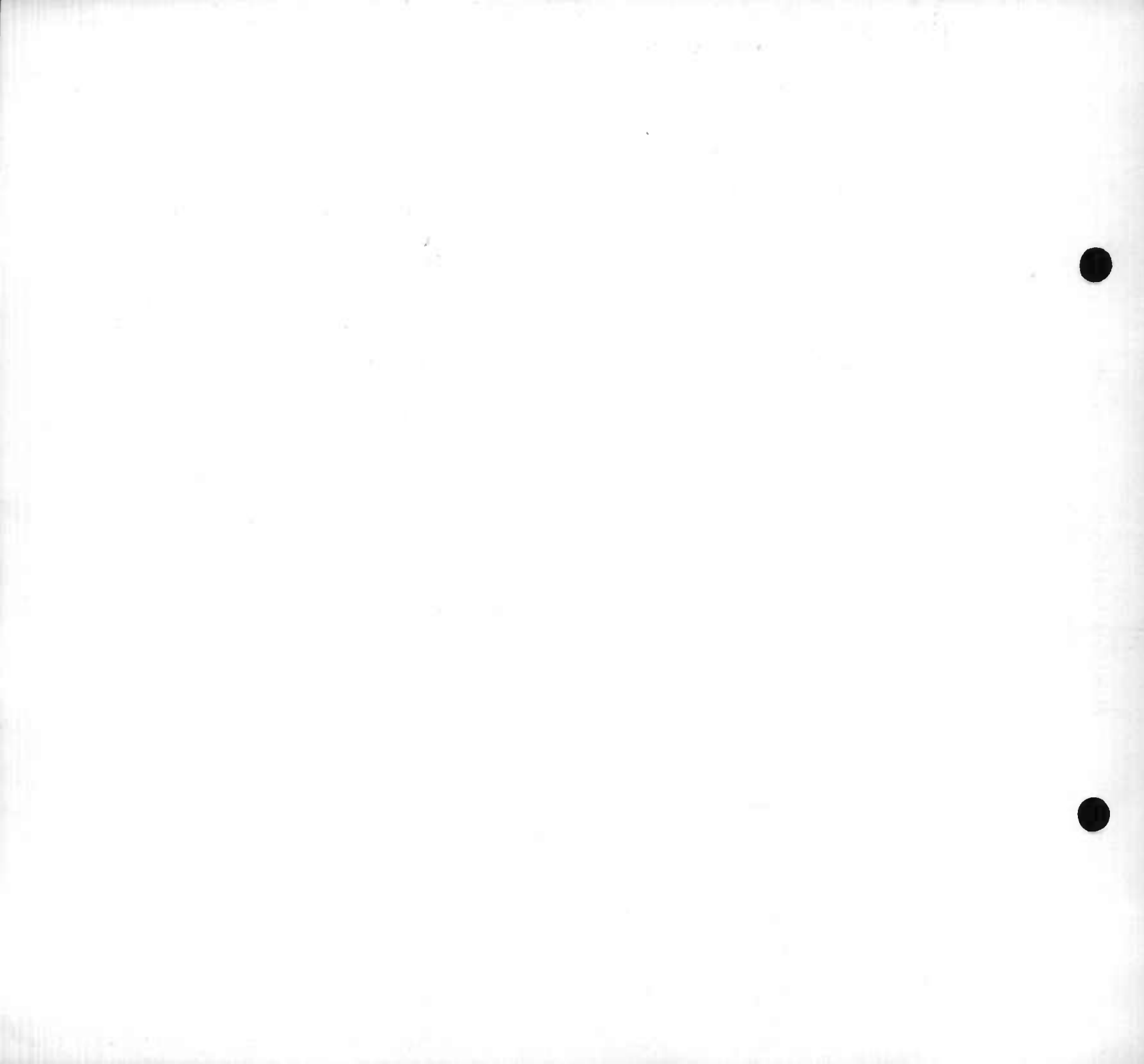
B-653		70 3556		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3556	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MARGARETE BRYANT</u>				2. DATE AND HOUR OF DEATH <u>1970 MARCH 30 6:58 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>42 SINAI HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 SINAI HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>W</u>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/23/93</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		9. AGE (in years last birthday) <u>77</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Daniel Tracey</u>				14. MOTHER'S MAIDEN NAME <u>Susan C. H. Trider</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Harry T Bryant</u>	
18. <u>412.2 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <u>② Middle Cerebral Artery Thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Hypertension</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>MAR. 22</u> 19 <u>70</u> to <u>MAR. 30</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>MAR. 30</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Victor Borden MD</u>				23B. DATE SIGNED <u>3/30/70</u>		23C. PHYSICIAN'S NAME (Type) <u>VICTOR BORDEN M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4-3-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Middletown Church Cem</u>	
24D. LOCATION (City, town, or county) (State) <u>Middletown Bt H Co Md</u>				25A. DATE REC'D. BY HEALTH DEPT. <u>1970 4-3-70</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>				25C. FUNERAL DIRECTOR <u>Burgess Funeral Home Bt H Co Md</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

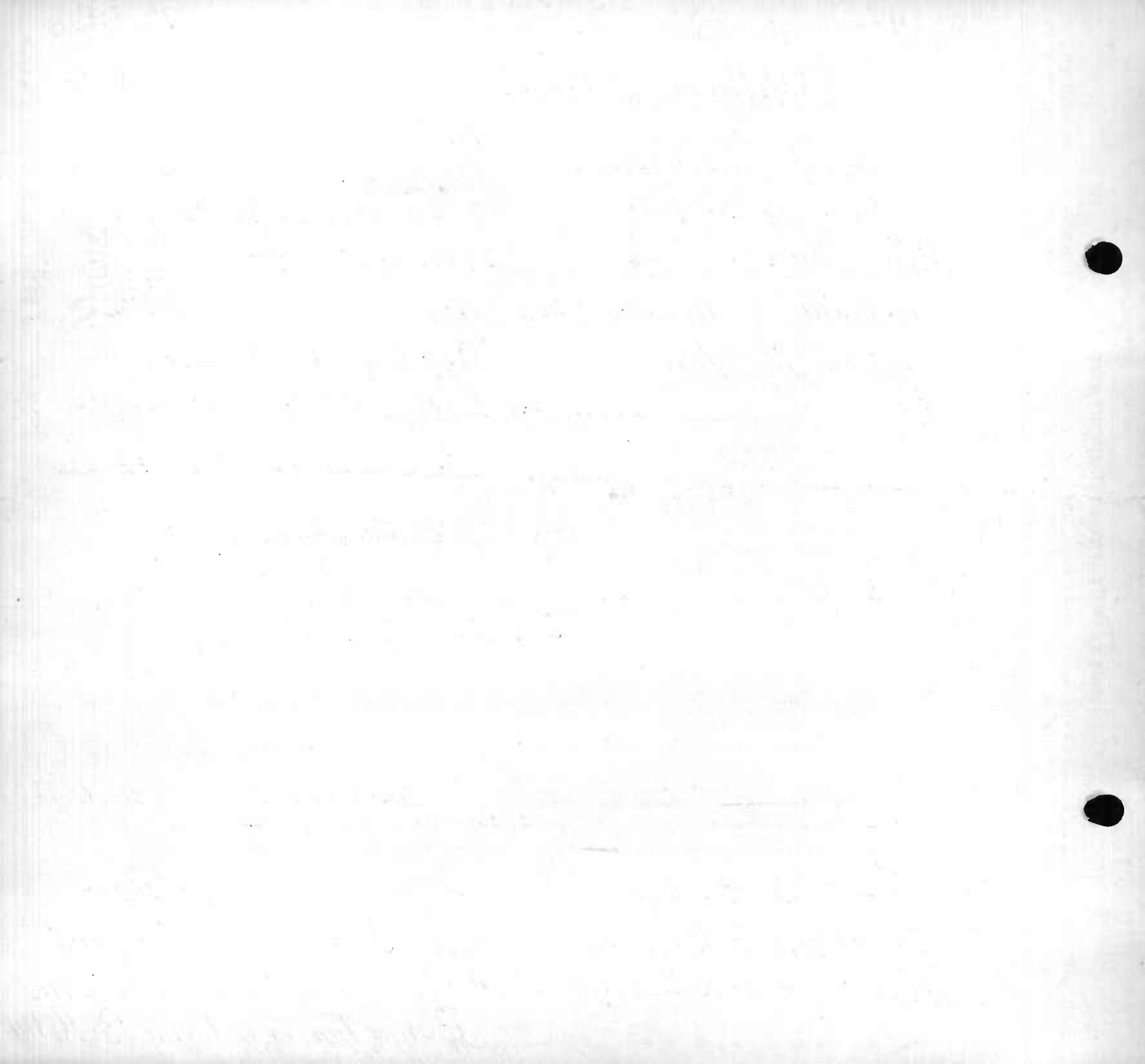
M-320		70 3557		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3557	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Elizabeth Anne Mathews</u>			
2. DATE AND HOUR OF DEATH <u>April 3, 1970</u> <u>12:15 A.M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1348</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u> <u>Mercy Hospital</u>				C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1419 Medfield Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED: <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-14-37</u>	9. AGE (In years last birthday) <u>32</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn O'Connor</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216 34 8356</u>		17. INFORMANT <u>John Mathews</u> ADDRESS <u>1419 Medfield Avenue</u>			
18. <u>448 X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Rupture of internal carotid aneurysm (angiogram).</u> 10 days -				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>MAR-24-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Internal Antidoteum</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>MAR-20-</u> 19 <u>70</u> to <u>MAR-AP-3-</u> 1970 that (I) (we) last saw the deceased alive on <u>April 2</u> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jorge R. Ordóñez</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>April-3-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>JORGE R. ORDONEZ MD</u>				23D. ADDRESS <u>MERCY HOSPITAL BAL. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-6-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Lakeview Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>CARROLL County Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1970</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, Reg.</u>		25C. FUNERAL DIRECTOR <u>BURGER FUNERAL HOME 3631 Falls Road</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3558	
W-420 70 3558		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) William B Wiles		2. DATE AND HOUR OF DEATH March 31 1970 8³⁰A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 1348			
FULL NAME OF HOSPITAL OR INSTITUTION Gould Convalesarium		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
90 6116 Belair Rd		E. STREET AND NUMBER 3503 Buena Vista Ave			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 Dec 1875	9. AGE (In years last birthday) 94	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanist		10B. KIND OF BUSINESS OR INDUSTRY Machine Shop		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William N Wiles		14. MOTHER'S MAIDEN NAME DAR K Y I Johnson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 10 7261		17. INFORMANT Evelyn J Redmond ADDRESS 1328 W 40th St	
18. 433.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Coronal Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours	
(B) Gravely Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic Brain Syndrome					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/28/1970 to 3/31/1970 , that (I) (was) last saw the deceased alive on 3/30/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.					
23A. SIGNATURE Albert B Bradley		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> OEGREE		23B. DATE SIGNED 4/3/70	
23C. PHYSICIAN'S NAME (Type) Dr Albert B Bradley		23D. ADDRESS 4900 Belair Rd Bk Hk Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-3-70	24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem		24D. LOCATION (City, town, or county) (State) Woodlawn Bk Hk Md	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970	25B. NAME OF REGISTRAR E. J. ...	25C. FUNERAL DIRECTOR Borgee Funeral Home		ADDRESS Bk Hk Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-322 70 3559		BALTIMORE CITY HEALTH DEPARTMENT		70 3559	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) HITCHCOCK, ROBERT L.		2. DATE AND HOUR OF DEATH 11:35 4-2-70 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1209 W. 41ST ST.					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/91	9. AGE (In years last birthday) 78	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME ROBERT L. HITCHCOCK		14. MOTHER'S MAIDEN NAME DELILIAH CHENOWETH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 07 5964		17. INFORMANT ADDRESS C HART	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASCVD, MI, CARDIOGENIC SHOCK		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4-10-91		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/2 4/2 70 and that (I) (we) last saw the deceased alive on 4/2 4/2 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harvey B. Sher M.D.		23B. DATE SIGNED 4/2/70			
23C. PHYSICIAN'S NAME (Type) HARVEY B. SHER M.D.		23D. ADDRESS UNION MEM. HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-6-70		24C. NAME OF CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION (City, town, or county) (State) Woodlawn Bldg Md					
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Paul E. Taylor		25C. FUNERAL DIRECTOR ADDRESS BURGER Funeral Home Bz/Hd Md	



FUNERAL DIRECTOR: IMPORTANT

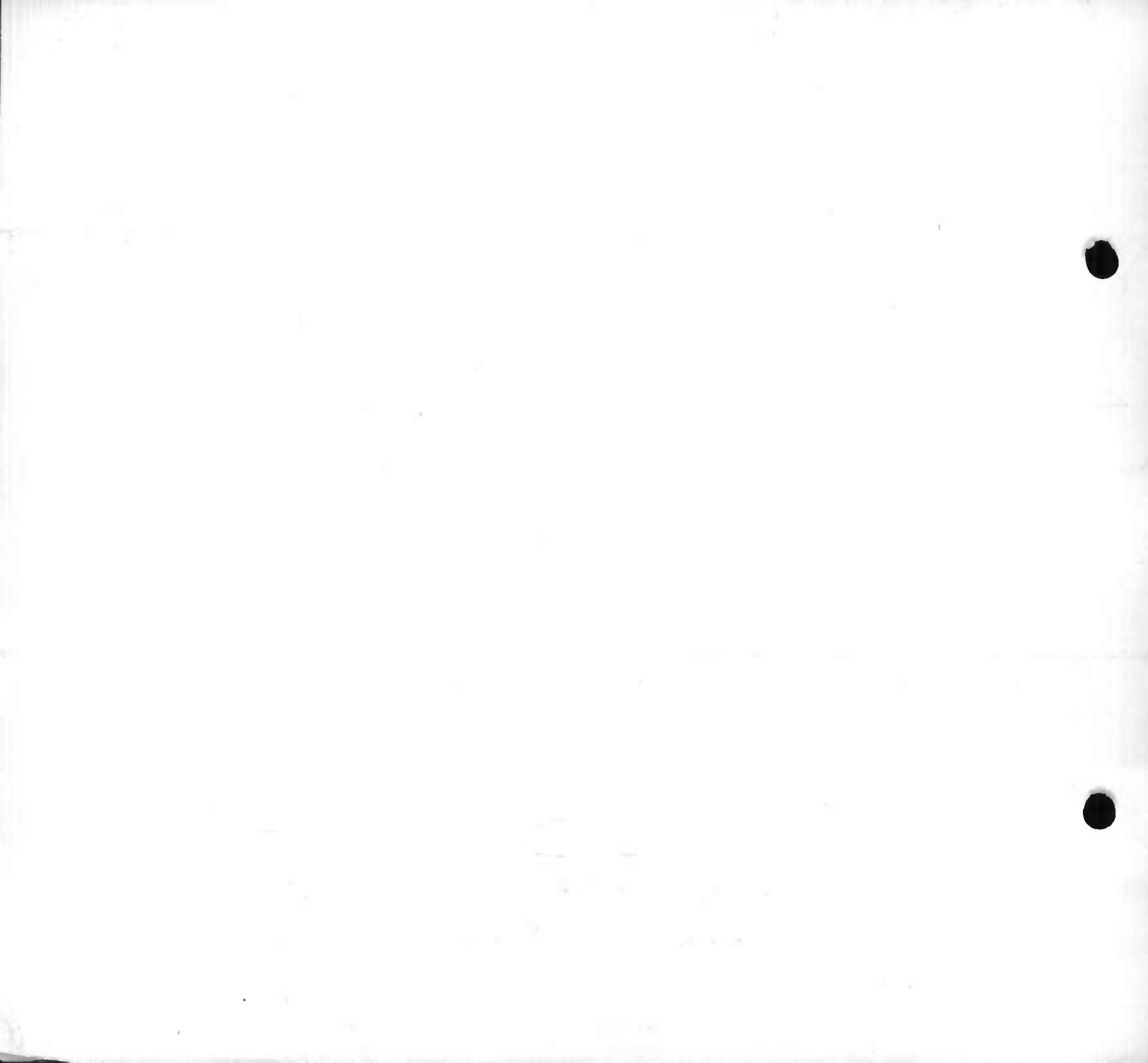
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3560		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3560	
1. NAME OF DECEASED (Type or Print) BARNETT, ARTHUR K.			2. DATE AND HOUR OF DEATH 4-4-70 10⁵⁵ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE Maryland B. COUNTY Baltimore		
C. CITY OR TOWN DUNDALK			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 39 Northship Road 21222					
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-1908	9. AGE (in years last birthday) 61	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) YARD FOREMAN		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel			
14. MOTHER'S MAIDEN NAME Mary HENRY LAWRENCE				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 170-14-2834		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 433.9 I Cerebrovascular Accidents			CAUSE OF DEATH (Thrombosis R middle cerebral art) Cerebrovascular Accidents		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pneumonia (2° to respiratory)					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from April 1 1970 to April 4 1970 that (1) (we) last saw the deceased alive on April 4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dale N. Schumacher M.D.			23B. DATE SIGNED 4-4-1970		
23C. PHYSICIAN'S NAME (Type) Dale N. Schumacher			23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-4-70		24C. NAME OF CEMETERY or CREMATORY PUNXSUTAWNEY	
24D. LOCATION (City, town, or county) (State) PUNXSUTAWNEY, PA.		25A. DATE REC'D BY HEALTH DEPT. APR 6 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS W. Burke Rodley, Rodley, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200		70 3561		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3561	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) LEWIS, MRS. Helen MARIE				4-4-70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL 2025 W. FAYETTE ST. BALTO. MD.				A. STATE MARYLAND B. COUNTY 2005			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 338 S. Smallwood St.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-24-15	9. AGE (In years last birthday) 54	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Southern Thompson				14. MOTHER'S MAIDEN NAME Helen Suit			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Wayne W. Lewis	
				ADDRESS Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 5-19-2 I CAUSE OF DEATH HYPOXIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC OBSTRUCTIVE (B) DUE TO, OR AS A CONSEQUENCE OF: AIRWAYS DISEASE (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 yrs.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 4-4-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HYPOXIA (TRACHEOTOMY)		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from 5-26 19 70 to 4-4 19 70 that (I) (we) last saw the deceased alive on 4-4-70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jain C. Kerr M.D. MB ChB				23B. DATE SIGNED 4-4-70			
23C. PHYSICIAN'S NAME (Type) JAIN C. KERR M.D. MB ChB				23D. ADDRESS BONSECOURS HOSP. BALTO # 23			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4 8 70		24C. NAME OF CEMETERY OR CREMATORY Meadowridge		24D. LOCATION (City, town, or county) (State) Dorsey, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR E. Taylor, R.A.		25C. FUNERAL DIRECTOR McGully		ADDRESS 130 E. Fort Ave	



C-416

70

3562

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3562

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

AUDREY CLIFFORD

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ March 30, 1970 1:45p M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

718 Gorsuch Ave. D.O.A.

3. DATE PRONOUNCED DEAD Month Day Year Hour
March 30 1970 1:45 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

905

6. SEX

Female

7. RACE

White

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Oct. 26, 1916

10. AGE (In years last birthday)

53

11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

718 Gorsuch Ave.

11. BIRTHPLACE (State or foreign country)

BALTO., MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

NICHODEMUS GRIMES

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOMEMAKER

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

MARGARET GRILL

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

216-01-9649

18. INFORMANT

ADDRESS

Mr. GORDON CLIFFORD

SAME

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of the chest
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

718 Gorsuch Ave. 2nd floor bedroom

22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)

3 30 70 9 a 1 p

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Self inflicted gunshot wound of chest

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz M.D. Deputy Chief Medical Examiner

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/31/70

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4/2/70

24C. NAME OF CEMETERY or CREMATORY

NEW CATHEDRAL CEM.

24D. LOCATION (City, town, or county) (State)

BALTO.

Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 6 1970

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MITCHELL-WIEDEFELD HOME 6500

YORK RD. BALTO. Md.

Oct. 28, 1916

WATERGATE, BAYVIEW
HONOLULU, HAWAII

NO 116-01-2549 Mr. Gordon Clifford

ACADEMIC RECORD

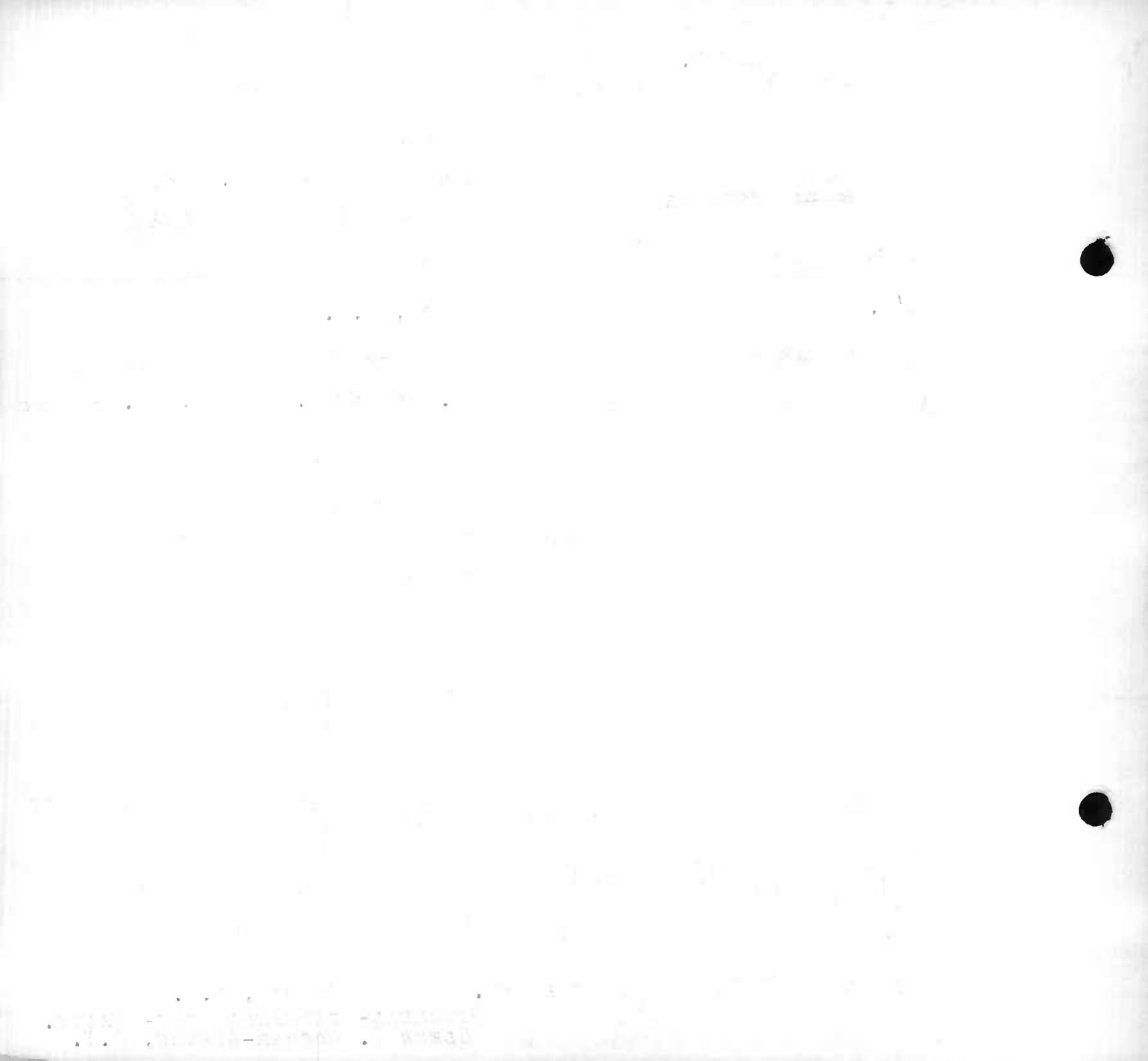
WATERGATE, BAYVIEW
HONOLULU, HAWAII

WATERGATE, BAYVIEW
HONOLULU, HAWAII

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

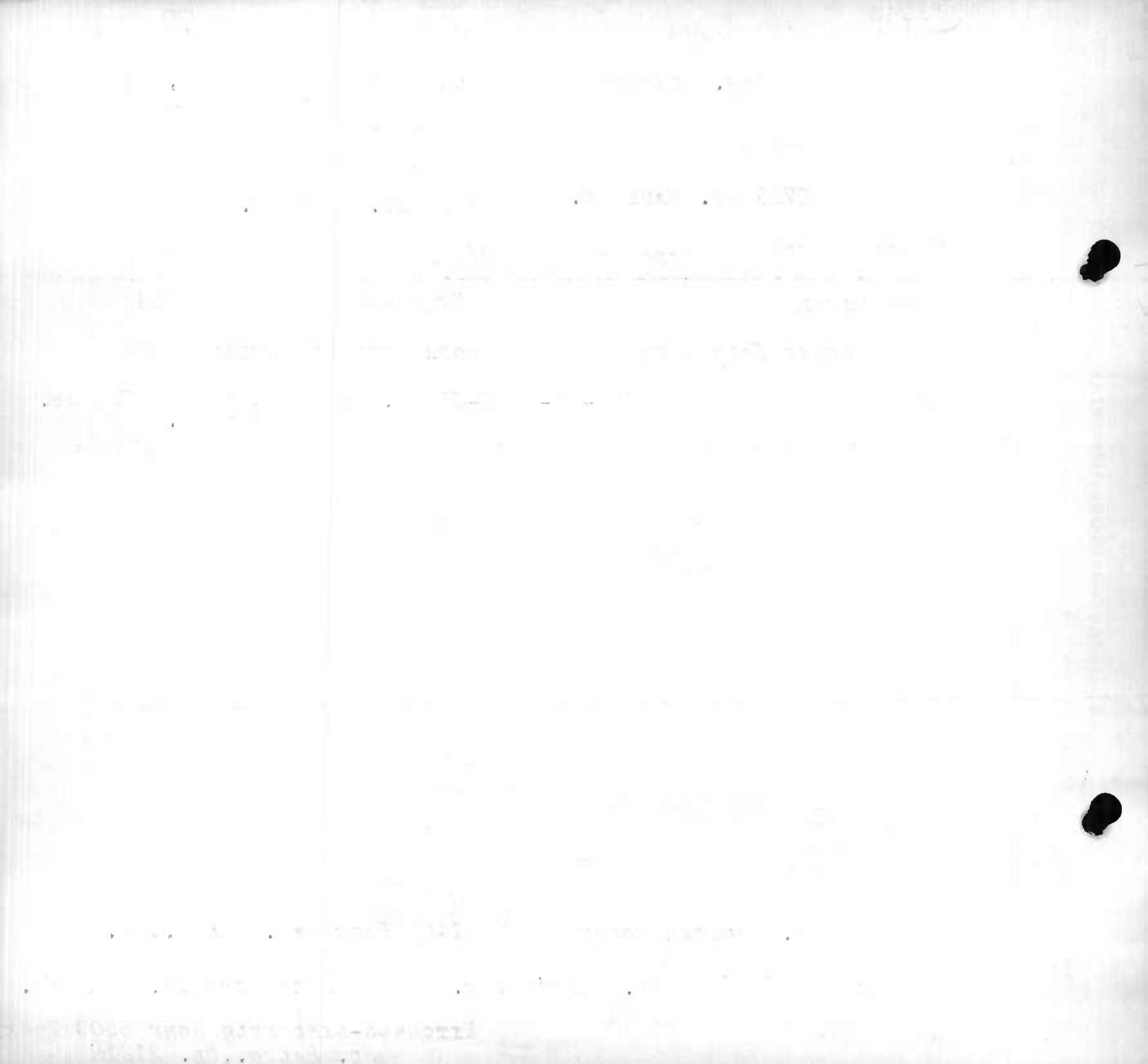
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
B-623 70 3563		70 3563		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANN T. BRIGHT		2. DATE AND HOUR OF DEATH 3-28-70 12 25 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 526 WINDWOOD			
5. SEX Female	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/06	9. AGE (in years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEC'y.		10B. KIND OF BUSINESS OR INDUSTRY BUILDERS		11. BIRTHPLACE (State or foreign country) FULTON, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK CRAHAN		14. MOTHER'S MAIDEN NAME NELLIE MEAR		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 074-05-4504		17. INFORMANT MR. ALBERT H. BRIGHT, JR. - SAME				ADDRESS	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Chronic Obstructive Lung disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Obstructive Lung disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(B) Arteriosclerosis Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: Chronic Bronchitis		YEARS			
(C) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-28 19 70 to 3-28 19 70 that (I) (we) last saw the deceased alive on 3-28 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Demetrius M. Drelanski		23B. DATE SIGNED 3/28/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type) DRELANSKI MD		23D. ADDRESS Sinai Hospital of Balto					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/2/70		24C. NAME of CEMETERY or CREMATORY FORT HILL CEM.		24D. LOCATION (City, town, or county) (State) AUBURN, N.Y.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Glenn F. Mosher		25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME - BALTO.			
				ADDRESS GLENN F. MOSHER - AUBURN, N.Y.			



FUNERAL DIRECTOR: IMPORTANT

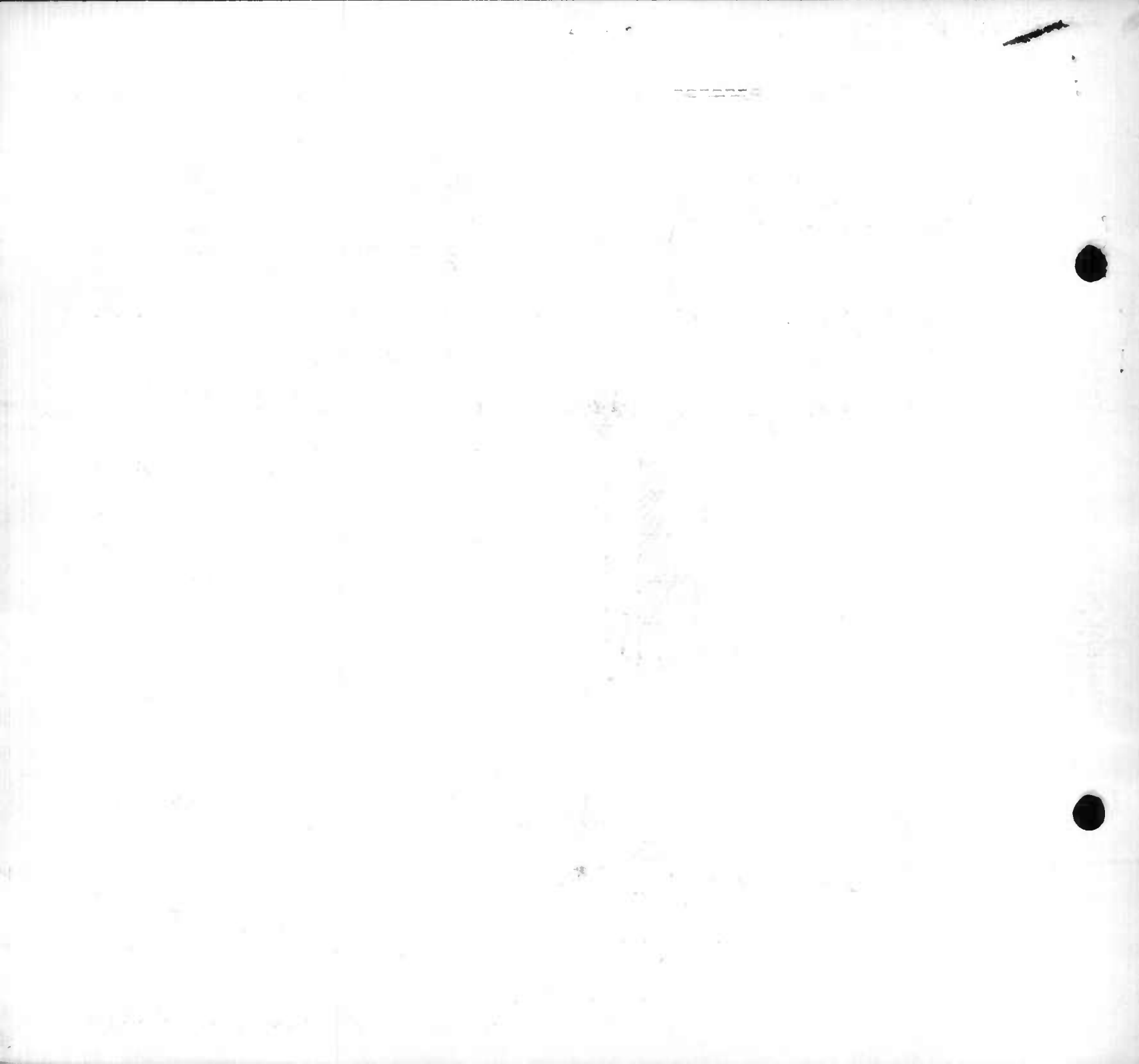
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-423 BIRTH NO.		70 3564		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 3564	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				Mrs. JEANNETTE CHEW CLAGGETT			
2. DATE AND HOUR OF DEATH				MARCH 28, 1970			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
00		2718 St. PAUL St.		MARYLAND		1206	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				BALTIMORE			
D. STREET ADDRESS (If rural, give location)				2718 St. PAUL St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
FEMALE	WHITE	WIDOWED	2/3/1877	93			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
HOMEMAKER					VIRGINIA		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
THOMAS JOHN CHEW				ROSA ROMMELLY DULANY CHEW			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO			220-44-8439-JI		MR. THOMAS CLAGGETT 2718 St. PAUL St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(1) Congestive Heart Failure		4-6 mos			
ANTECEDENT CAUSES		(A) Advanced Cerebro Vascular Disease					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Hypertension					
		(C) Anemia - Secondary to Nutritional Deficiency					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Oct 1952 to 3-28 1970, that (I) (we) last saw the deceased alive on 3-28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. William Woody						3-31-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		M.D.			
DR. WILLIAM WOODY		1403 PARK AVE. BALTO., MD.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		3/31/70		St. MARK'S CEM.		FREDERICK Co. MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 6 1970		John E. Taylor, M.D.		MITCHELL-WIEDEFELD HOME		6500 YORK RD. BALTO., MD. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

56-11-07 B-622 70 3565		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X		REG. NO. 70 3565	
1. NAME OF DECEASED (Type or Print) Charles Barnett BERGQUIST		2. DATE AND HOUR OF DEATH April 3, 1970 7:45 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7707 Norbush Avenue 21222			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-05	9. AGE (in years last birthday) 64	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BURNER/WELDER		10B. KIND OF BUSINESS OR INDUSTRY STEEL MFG-R.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Victor BERGQUIST		14. MOTHER'S MAIDEN NAME Elizabeth HALE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 3-15-25/5-17-26		16. SOCIAL SECURITY NO. 213-09-3592		17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anoxic Encephalopathy & Acute Tubular Necrosis (B) Multiple Cardiac Arrest (C) COPD, Acute Foreign Body in Esophagus 5th bleeding; Foreign body in esophagus.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/29 3/28 3/24	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 3/30		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheostomy		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Swallowed quarter while drunk.	
22. I certify that (1) (this hospital) attended the deceased from 4/1/70 to 4/3/70 that (1) (we) last saw the deceased alive on 4/3/70 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward J. Lee MD		23B. DATE SIGNED 4/3/70		23C. PHYSICIAN'S NAME (Type) Edward J. Lee M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-6-70		24C. NAME of CEMETERY or CREMATORY MEADOWRIDGE	
24D. LOCATION (City, town, or county) DORSEY, Md.		24E. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224		24F. FUNERAL DIRECTOR	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR	



M-343

70

3566

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

3566

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Middleton

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

4

4

70

3:45 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

July 1, 1887

10. AGE (In years
last birthday)

82

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1827 S. Charles St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Unknown Middleton

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Policeman-Retired

14B. KIND OF BUSINESS OR INDUSTRY

Law Enforcement

15. MOTHER'S MAIDEN NAME

Unknown Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

William W. Parks 1827 S. Charles St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

4/4/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4 7 70

24C. NAME OF CEMETERY or CREMATORY

Meadowridge

24D. LOCATION (City, town, or county)

Dorsey, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

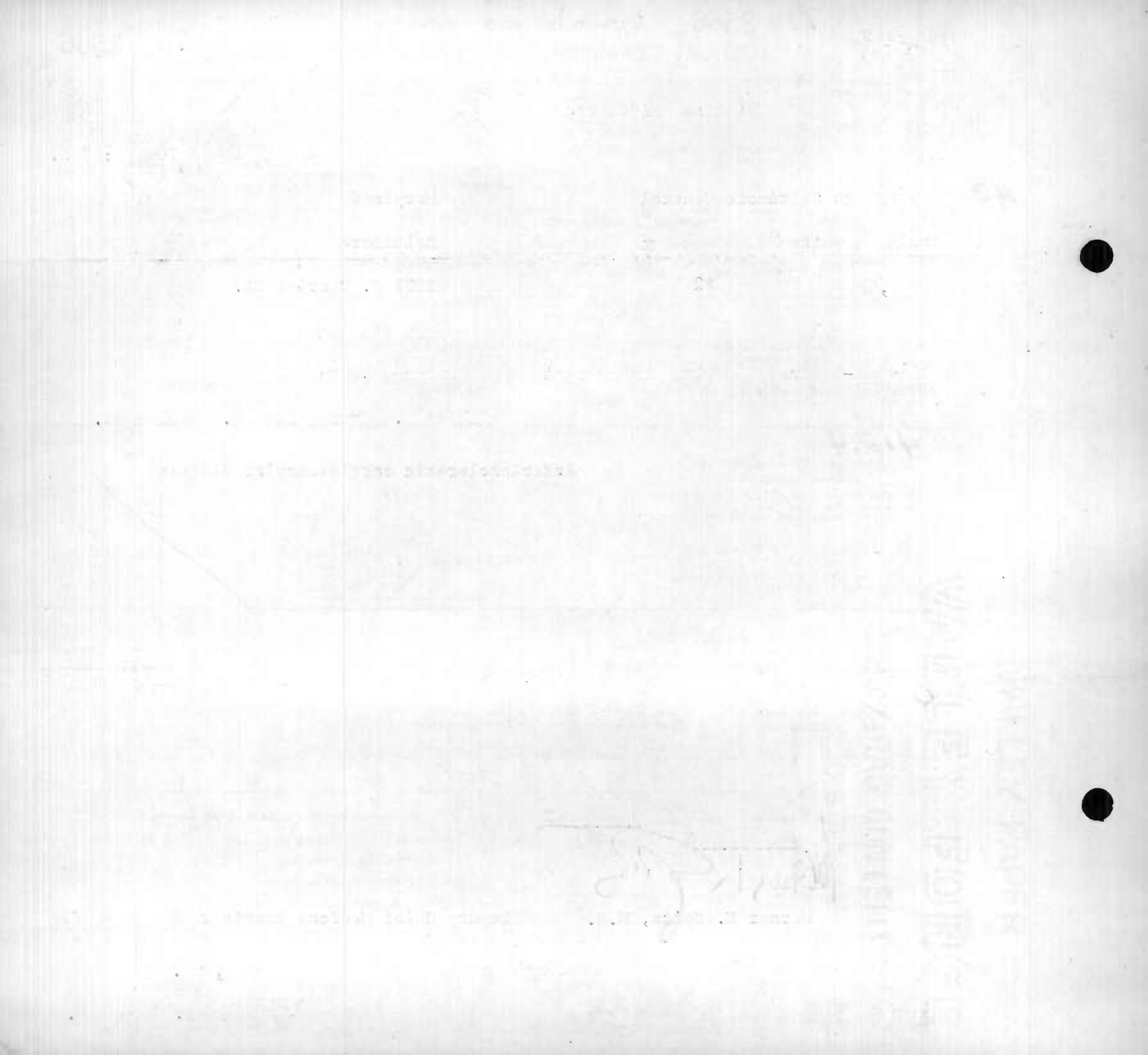
ADDRESS

APR 6 1970

Robert E. Taylor, M.D.

Mc Gully

130 E. Fort Ave.



BIRTH NO.		REG. NO.	
K-200 70 3567		70 3567	
1. NAME OF DECEASED (Type or Print) BENJAMIN H. KAISS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1720 St. Paul Street, Apt. 310		3. DATE PRONOUNCED DEAD Month Day Year March 31, 1970 9:00 P. M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1205	
7. RACE White		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1720 St. Paul Street, Apt. 310	
9. DATE OF BIRTH JULY 3, 1887 June 8, 1888		10. AGE (In years lost birthday) 87 11/11/82	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ernst Kaiss		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto salesman-retired	
15. MOTHER'S MAIDEN NAME Kohler		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes US Navy	
17. SOCIAL SECURITY NO.		18. INFORMANT Family records U.S. Navy Records	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/1/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/3/70	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Harvey, R.D.	
25C. FUNERAL DIRECTOR John Burns Sons		ADDRESS Towson Md.	

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THE MEDICAL & SURGICAL DEPARTMENT OF THE

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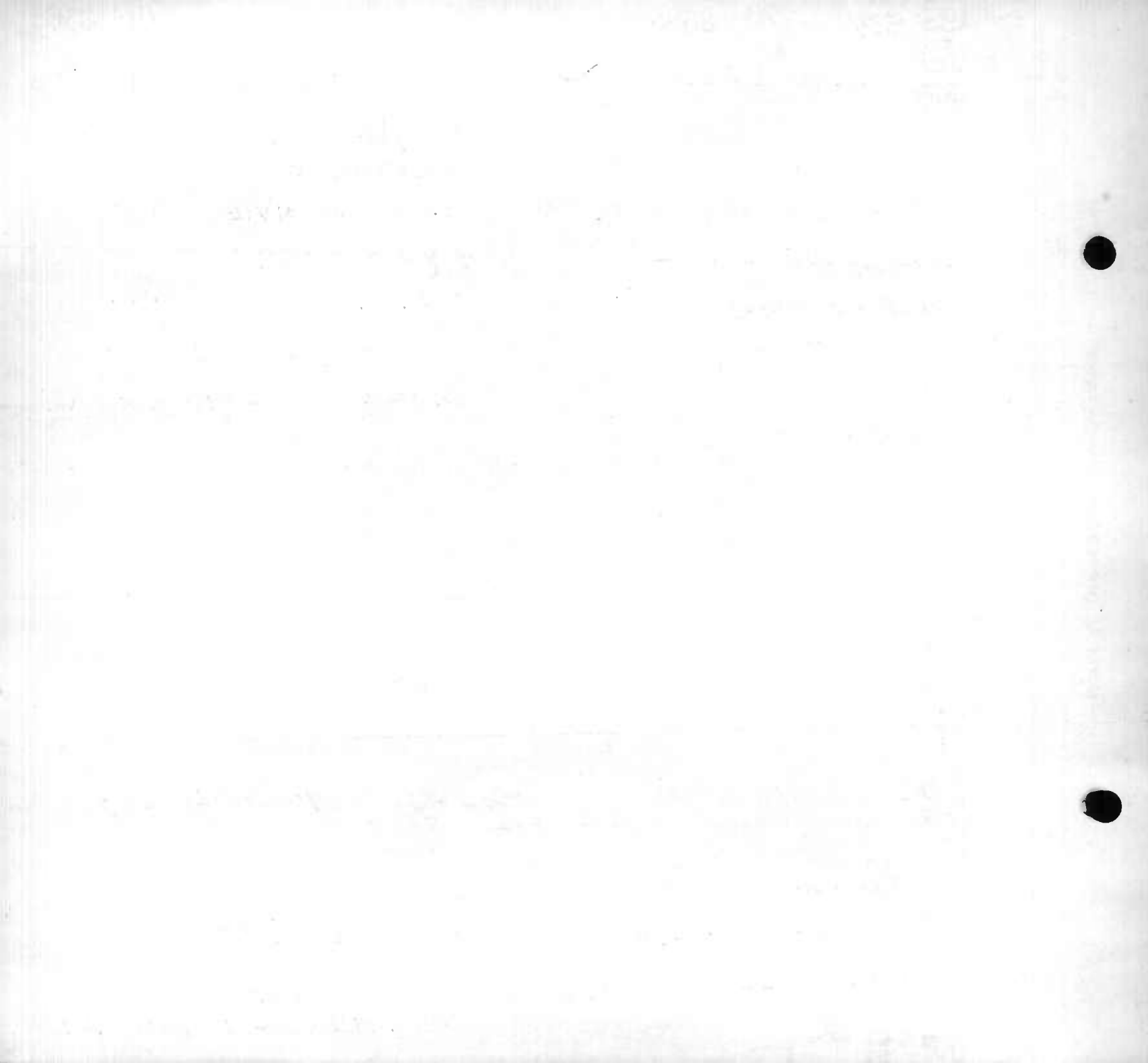
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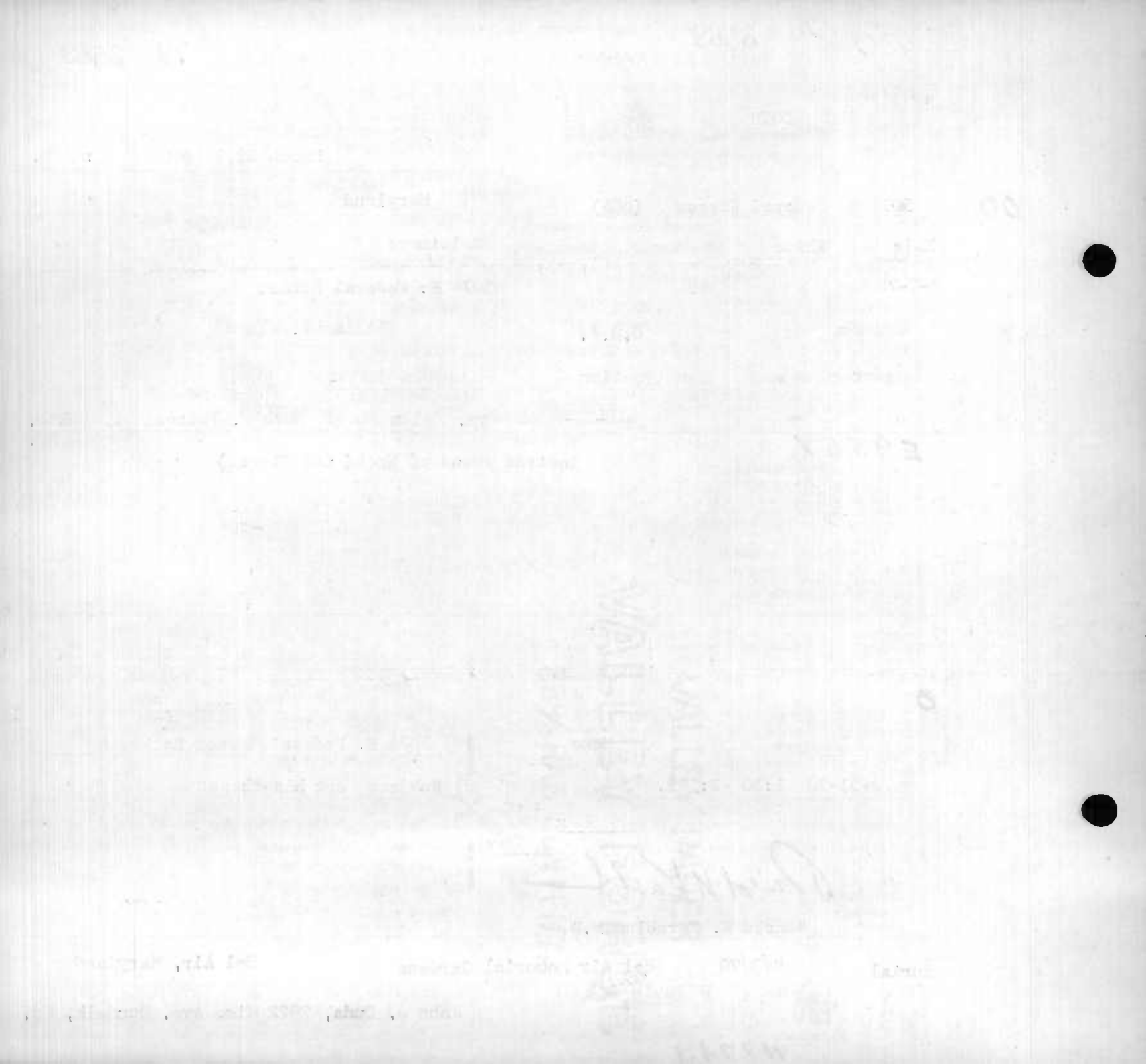
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
L-534 70 3568		70 3568		70 3568	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John A. LANDLER		4/2/70 112 ²⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN Hospital of Md.		A. STATE MARYLAND		B. COUNTY 841	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3213 LAWNVIEW AVE			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-8-10	9. AGE (In years last birthday) 59	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY Wholesale Meats		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles L'ndler		14. MOTHER'S MAIDEN NAME Sophia Kirsch	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Stella Landler - 3213 Lawnview Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 431.9 I CAUSE OF DEATH Intracranial hemorrhage 3 hours		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) showing the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9:30 AM 4/2 1970 to 12:20 PM 4/2 1970, that (I) (we) last saw the deceased alive on 12:20 4/2 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lee Russo		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) LEE RUSSO	
23D. ADDRESS 1010 St Paul St.		23E. DEGREE		23F. ADDRESS Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-6-70		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 6 1970		24F. NAME OF REGISTRAR John C. Miller Inc-6415 Belair Rd.-21206	
24G. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206		24H. ADDRESS		24I. DATE	



F-430 70 3569		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 3569	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) BUD FLOYD				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5074 E. Federal Street (DOA)				3. DATE PRONOUNCED DEAD Month Day Year March 31, 1970 2:45 P.M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3-7-08				10. AGE (In years last birthday) 62		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William F. Floyd		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2653	
15. MOTHER'S MAIDEN NAME Lydia Gunter				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 418-07-8224				18. INFORMANT Wife: ADDRESS Mrs. Helen Floyd 5074 E. Federal St. Balto.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Incised wound of Neck (Cut Throat) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E9567				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) no				22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5074 E. Federal Street, Bathroom			
22D. TIME (Month) (Day) (Year) (Hour) 3-31-70 1:30 - 2:20 P.M.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Subject cut his throat				23.			
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/3/70			
24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens				24D. LOCATION (City, town, or county) (State) Bel Air, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970				25B. NAME OF REGISTRAR John J. Duda			
25C. FUNERAL DIRECTOR John J. Duda				ADDRESS 7922 Wise Ave. Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

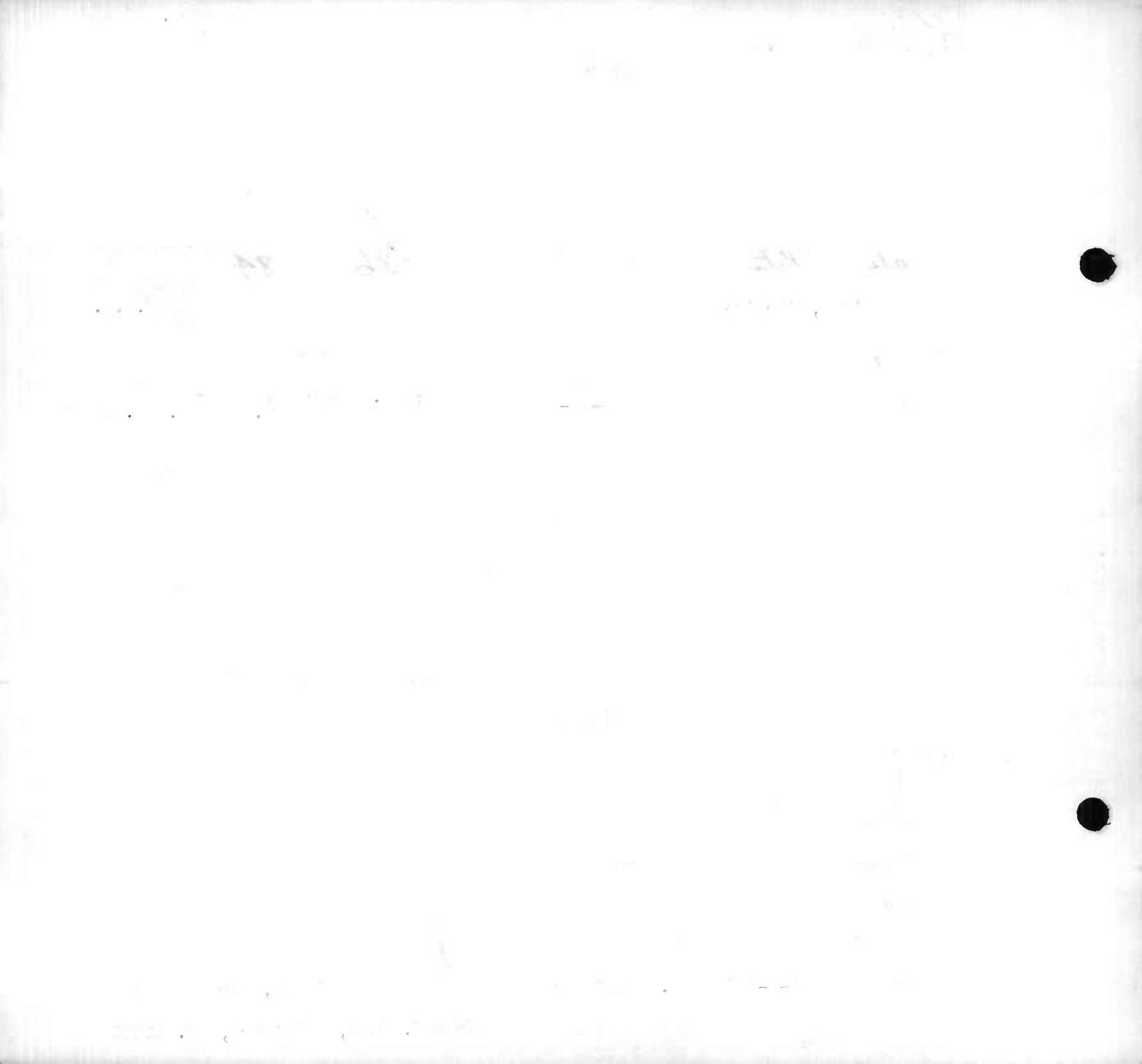
56-58-83 d's		70 3570		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3570	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Henry J. Ruppel		2. DATE AND HOUR OF DEATH 4/1/70 845 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21222				C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 7310 School Avenue							
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-19	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Design		10B. KIND OF BUSINESS OR INDUSTRY Martin Marietta Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry J. Ruppel, Sr.				14. MOTHER'S MAIDEN NAME Agnes Salahlman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 212-01-5640		17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(A) IMMEDIATE CAUSE acute MI							
(B) Chronic renal failure							
(C) ASCVD							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 3/31 19 70 to 4/1 19 70, that (1) (we) last saw the deceased alive on 4/1 19 70 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Lynne J. Neefe, MD				23B. DATE SIGNED 4/1/70			
23C. PHYSICIAN'S NAME (Type) Lynne J. Neefe M.D.				23D. ADDRESS C/o Balto. City Hosps		4940 Eastern Ave. Balto. Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-6-70		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3571	
K-160 70 3571 CERTIFICATE OF DEATH					
BIRTH NO. K-160		1. NAME OF DECEASED (Type or Print) JOHN KABARA		2. DATE AND HOUR OF DEATH 4/1/70 9:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 34 BOW SECOURS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1301		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BOW SECOURS HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2401 EUTAW PLACE		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-15-86	9. AGE (In years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, farming		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME CASIMIR KABARA			14. MOTHER'S MAIDEN NAME Agnes Kolodziej		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-5065		17. INFORMANT Nephew: Mr. Edward J. Kabara 307 Elrino St. Balto. Md. 21224	
18. 44701 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH IRREVERSIBLE STROKE. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Dissection Aortic Aneurysm (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD + Arterial Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/31 19 70 to 4/1 19 70 that (I) (we) last saw the deceased alive on 4/1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mayuree Khongchavansak, M.D.				23B. DATE SIGNED 4/1/70	
23C. PHYSICIAN'S NAME (Type) MAYUREE KHONGCHAVANSUK, M.D.				23D. ADDRESS Bow Secours Hosp. Balto., Md. 21223.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-4-1970		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
24D. LOCATION Baltimore, Maryland 21224		25A. DATE REC'D BY HEALTH DEPT. APR 6 1970			
25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR John J. Duda, Baltimore, Md. 21224			



B-400

70 3572

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3572

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VIRGINIA BEALL		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 3 70 6:45 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION University Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour April 3, 1970 6:45 a.m.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 11/17/28		10. AGE (In years lost birthday) 41	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assorter		14B. KIND OF BUSINESS OR INDUSTRY Home Furnishings	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT John Winans		ADDRESS 1337 W. Lombard St. 21223	
19. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 21		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/3/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 04/06/70	
24C. NAME OF CEMETERY OR CREMATORY Sater's Baptist Cem.		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Jacoby, M.D.	
25C. FUNERAL DIRECTOR Walters Funeral Home		ADDRESS Pratt & Stricker Sts.	

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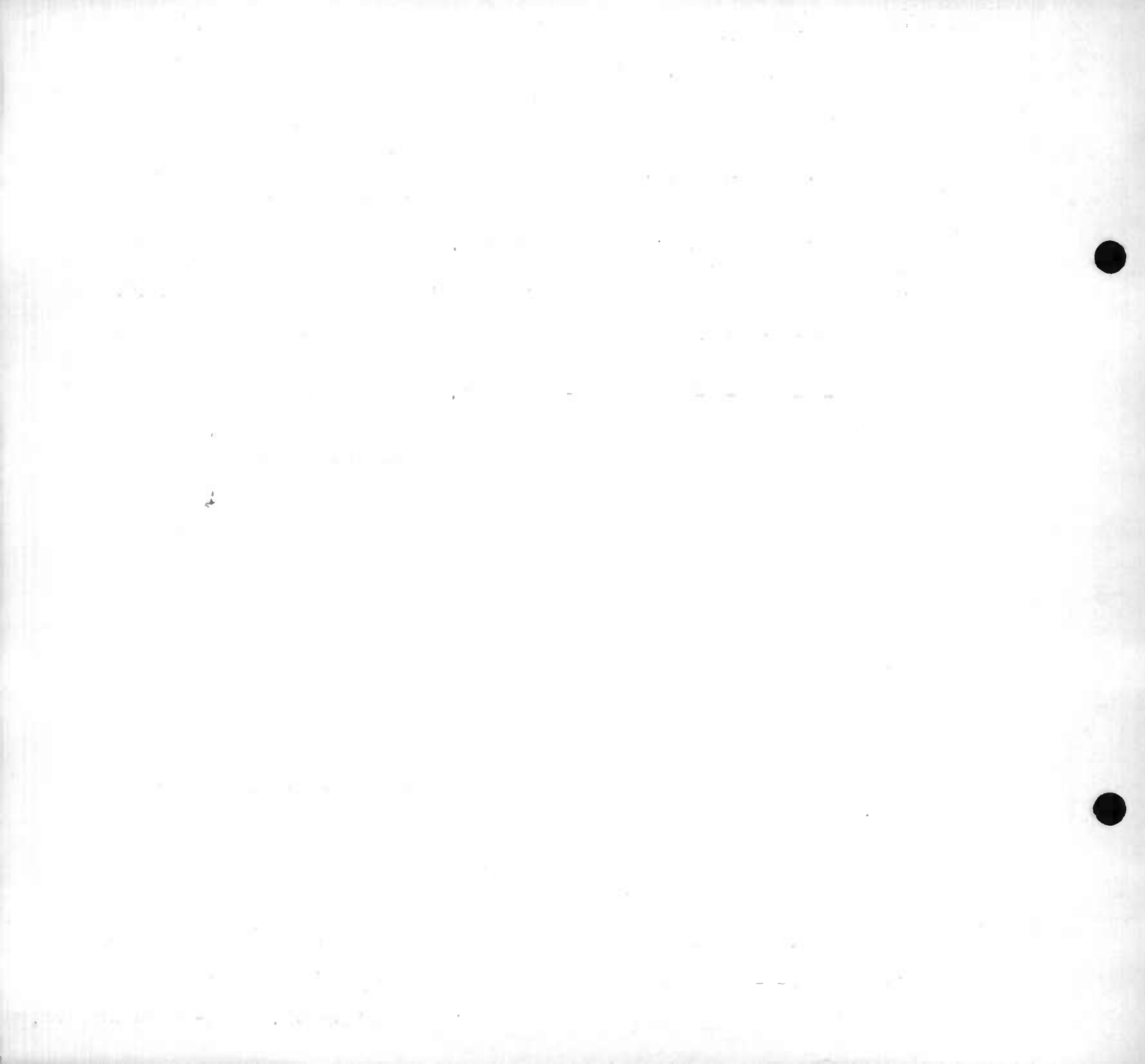
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 70 3573	
BIRTH NO. 0-164 70 3573		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GEORGE T. OBERLANDER		2. DATE AND HOUR OF DEATH March 31, 1970	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		A. STATE Maryland B. COUNTY 2609			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3810 Hudson Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED Married	8. DATE OF BIRTH Jan. 23, 1921	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Humble Standard Oil		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Phillip Oberlander		14. MOTHER'S MAIDEN NAME Mary Sammeth			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Yes 8-11-42 5-29-44		16. SOCIAL SECURITY NO. 218-07-6503		17. INFORMANT Mrs. Anna Oberlander	
				ADDRESS 3810 Hudson Street	
18. I 1959 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Generalized carcinomatosis		CAUSE OF DEATH (A) Generalized carcinomatosis DUE TO (B) Cancer of neck DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 months 1 year	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from September 27 1968 to March 31 1970 , that (I) (we) lost saw the deceased alive on March 31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 5:30 pm					
23A. SIGNATURE Artemio M. Arciaga, Jr.				23B. DATE SIGNED 4/3/70	
23C. PHYSICIAN'S NAME (Type) ARTEMIO M. ARCIAGA, JR.		23D. ADDRESS M.D. 3501 Fait Avenue, Baltimore Md 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-4-1970		24C. NAME of CEMETERY or CREMATORY Oak Lawn	
				24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.	
				ADDRESS 1901-07 Eastern Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-625 70 3574				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3574	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) Ann Edna Norjen				2. DATE AND HOUR OF DEATH April 2, 1970 7:23 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 214 E. Melrose Ave		A. STATE Maryland		B. COUNTY 2712	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 214 E. Melrose Ave			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept, 4, 1894		9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lynch				14. MOTHER'S MAIDEN NAME Kathryn Daly			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Claire M Norjen		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) 0-3-89 Septicemia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1. Marked arteriosclerosis 2. Cerebrovascular accident 3. Multiple infarct ischemic 4. Chronic Brain Syndrome ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 6 1969 to March 21 1970 , that (I) was last saw the deceased alive on March 21 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Jamshid Hamed M.D.				23B. DATE SIGNED 4/3/70		23C. PHYSICIAN'S NAME (Type) Jamshid Hamed M.D.	
23D. ADDRESS 204 E Joppa Rd Baltimore, Maryland							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/6/70		24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. J. [unclear]		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3575	
<div style="display: flex; justify-content: space-between;"> S-400 70 3575 </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> BIRTH NO. 1. NAME OF DECEASED (Type or Print) KENNEDY KIRK SHELLEY </div> <div style="width: 35%;"> 2. DATE AND HOUR OF DEATH April 3, 1970. 2:30 A.M. </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div style="width: 50%;"> FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital-DOA </div> <div style="width: 50%;"> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> A. STATE Md. </div> <div style="width: 60%;"> B. COUNTY 2748 </div> </div>		
5. SEX Male			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 14, 1908.		9. AGE (In years last birthday) 61		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Charles K. Shelley		
14. MOTHER'S MAIDEN NAME Rose Cole			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 212-03-2018		17. INFORMANT Mrs. Florence F. Shelley		ADDRESS (Same)	
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Myocardial Infarction 6 hours DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Heart Disease 8 years DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1965 to April 2 1970. that (I) (we) lost saw the deceased alive on March 25 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Franklin E. Leslie				23B. DATE SIGNED 4/3/70	
23C. PHYSICIAN'S NAME (Type) Franklin E. Leslie				23D. ADDRESS 3501 St Paul St. Balt. Md 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4/6/70.		24C. NAME OF CEMETERY or CREMATORY Greenmount Crematory	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 6 1970 25B. NAME OF REGISTRAR Bub E. Talley, R.D.			
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS	

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BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3576

BIRTH NO.

1. NAME OF DECEASED (Type or Print) M. ELIZABETH GORDON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 4 2 70 11:55 a.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 2924 Erdman Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour April 2, 1970 11:55a M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH April 22, 1925.		10. AGE (In years lost birthday) 44	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder		15. MOTHER'S MAIDEN NAME Sophia Labor	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-26-0420	
18. INFORMANT Mr. William M. Gordon		ADDRESS (Same) (Same)	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/6/70.	
24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto. Md. 21214	

Baltimore, Md.

Baltimore National Cemetery

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Edward J. Mack, Inc. Baltimore, Md. 21201

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3577	
BIRTH NO. 2-532		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHARLES E. ZENTGRAF		2. DATE AND HOUR OF DEATH April 3, 1970.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2805 Alvarado Square		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2757 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2805 Alvarado Square	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1900.
9. AGE (In years last birthday) 69		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Insurance Agent		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Zentgraf		14. MOTHER'S MAIDEN NAME Emma /?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-6526	
17. INFORMANT Mrs. Mildred A. Zentgraf		ADDRESS (Same)	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SCUTE MYOCARDIAL INFARCTION. WHEN ARTERIO-SCLEROTIC HEART DISEASE 104RS		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1966 to April 1970 , that (I) (we) last saw the deceased alive on March 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Francis T. Daly		23B. DATE SIGNED April 3rd 1970	
23C. PHYSICIAN'S NAME (Type) FRANCIS T. DALY		23D. ADDRESS 11 E. Chase St., Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/6/70.	24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970	25B. NAME OF REGISTRAR Robert E. J. [unclear]	25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	

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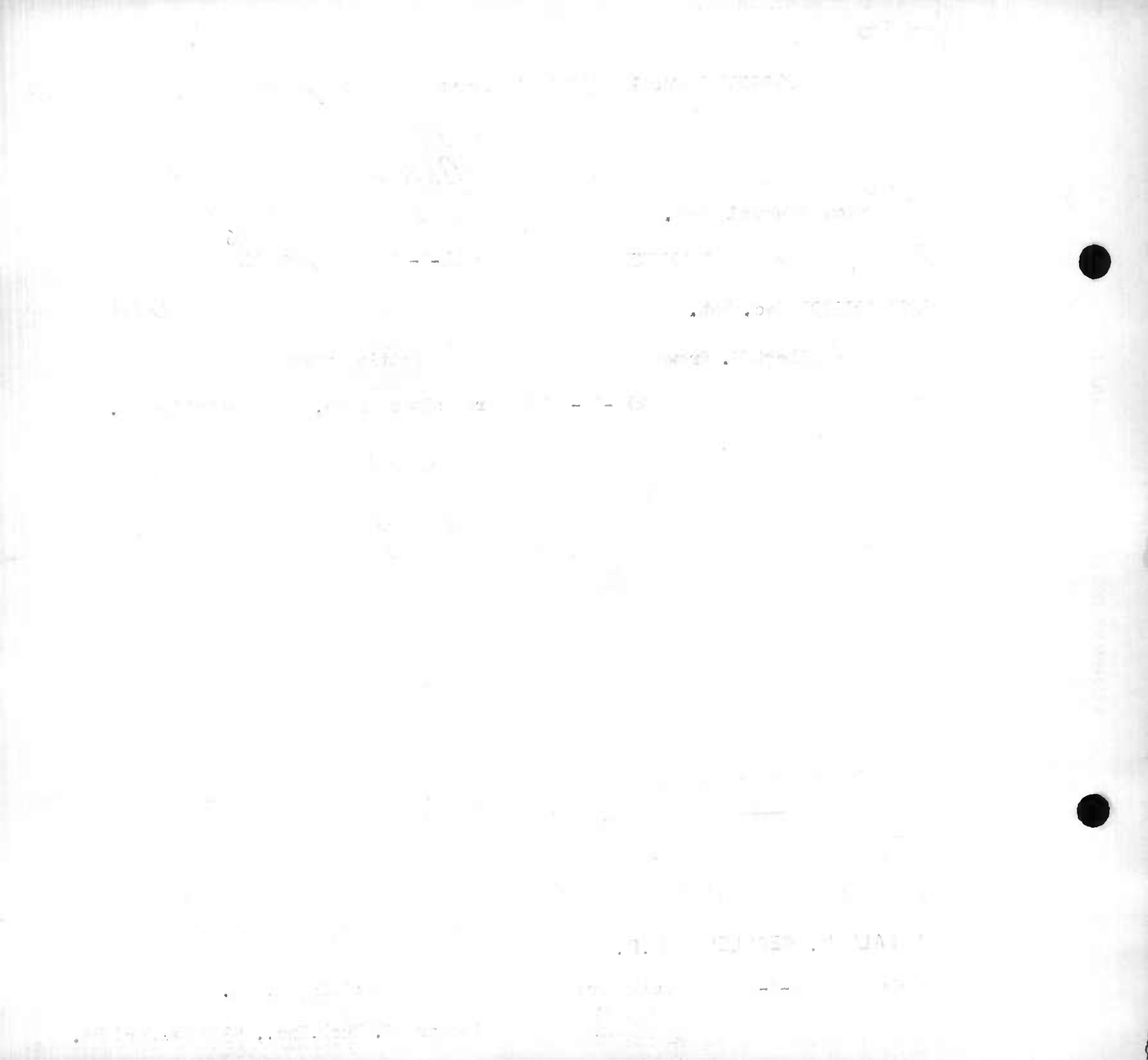
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

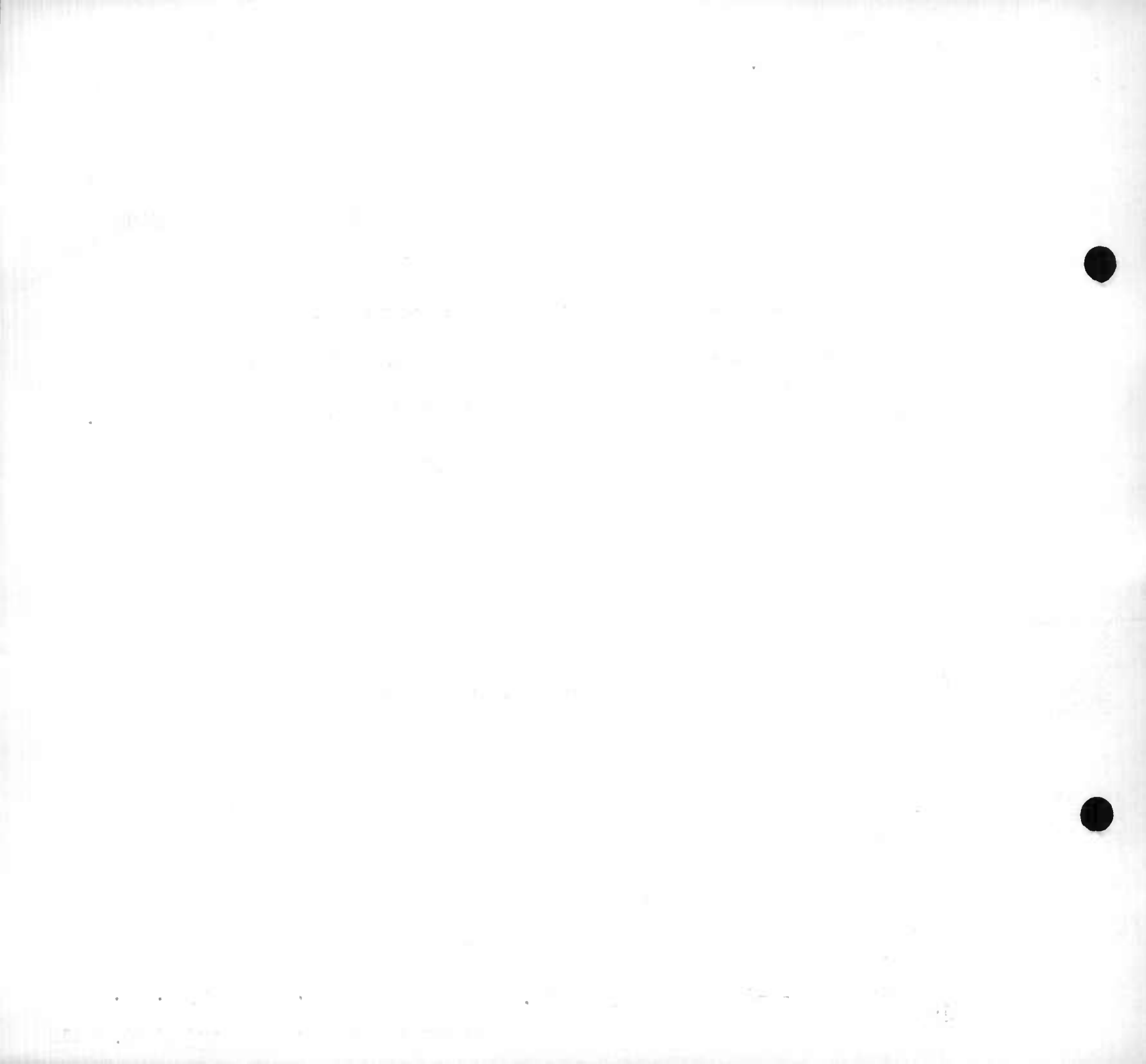
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3578</u>	
BIRTH NO. <u>B-656 70 3578</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>XXXXXXXXXX Mabel XXXXXXXXXX Brown</u>		2. DATE AND HOUR OF DEATH <u>4/3/70 8:05 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u> <u>Union Memorial Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2749</u>			
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>MARRIED</u> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXXXXXX Sec. Ret.</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>? 11-1-83</u>	
13. FATHER'S NAME <u>Albert S. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Wayson</u>		9. AGE (In years) <u>86</u> lost birthday <u>8/7/74</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-10-1417A</u>		17. INFORMANT ADDRESS <u>Ira Walter Brown, 1506 Pentridge Rd.</u>	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CVA</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 mos</u> <u>MANY YEARS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2/21/70</u> to <u>4/3/70</u> and that (I) (we) lost saw the deceased alive on <u>4/3/70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald W. Geckler M.D.</u> DEGREE				23B. DATE SIGNED <u>4/3/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>RONALD W. GECKLER M.D.</u> DEGREE				23D. ADDRESS <u>Union Memorial Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-7-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc., 5305 Harford Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-260 70 3579		BALTIMORE CITY HEALTH DEPARTMENT	
CERTIFICATE OF DEATH X		REG. NO. 70 3579	
1. NAME OF DECEASED (Type or Print) GEORGE GOSKER SR.		2. DATE AND HOUR OF DEATH APRIL 1 1970 6³⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL 48		A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box 325 Route # 16 21220	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/4/1900 9. AGE (In years lost birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dispatcher Gas & Electric		11. BIRTHPLACE (State or foreign country) New York	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Gosker		14. MOTHER'S MAIDEN NAME Louise (notknown)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-4307A	
17. INFORMANT Mollie E Gosker		ADDRESS Box 325 Rt. # 16 21220	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CARDIO RESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE 2° ASCVD SEVERE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF:	
		(C) B K AMPUTATION	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		EXP LAP FOR BLEEDING PROBLEMS 4/5 MAR	
19A. DATE OF OPERATION 15 MAR 30 MAR	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DIABETIC BLEEDING ULCER GANGRENE	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 3/2/70 19 to 4/1/70 19 that (I) (we) last saw the deceased alive on 4/1/70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. S. Oldroyd M.D.		23B. DATE SIGNED 4/1/70	
23C. PHYSICIAN'S NAME (Type) J. S. Oldroyd M.D.		23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION
Burial	4-4-70	Holly Hill Cem.	Balto. Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR Leonard J. Ruck Inc ADDRESS 5305 Harford Rd. 21214	



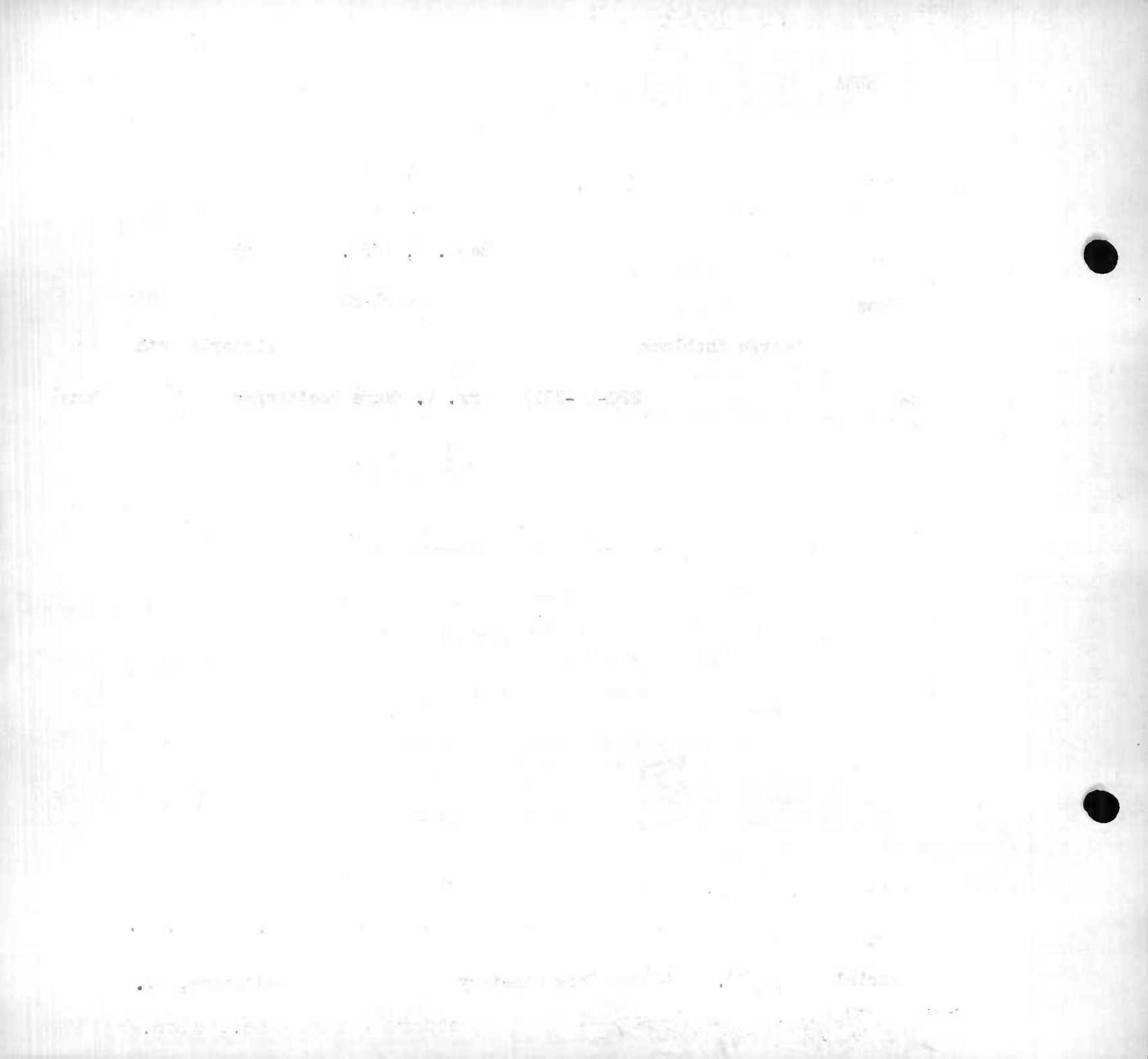
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV, 1/1/6B

FUNERAL DIRECTOR: IMPORTANT

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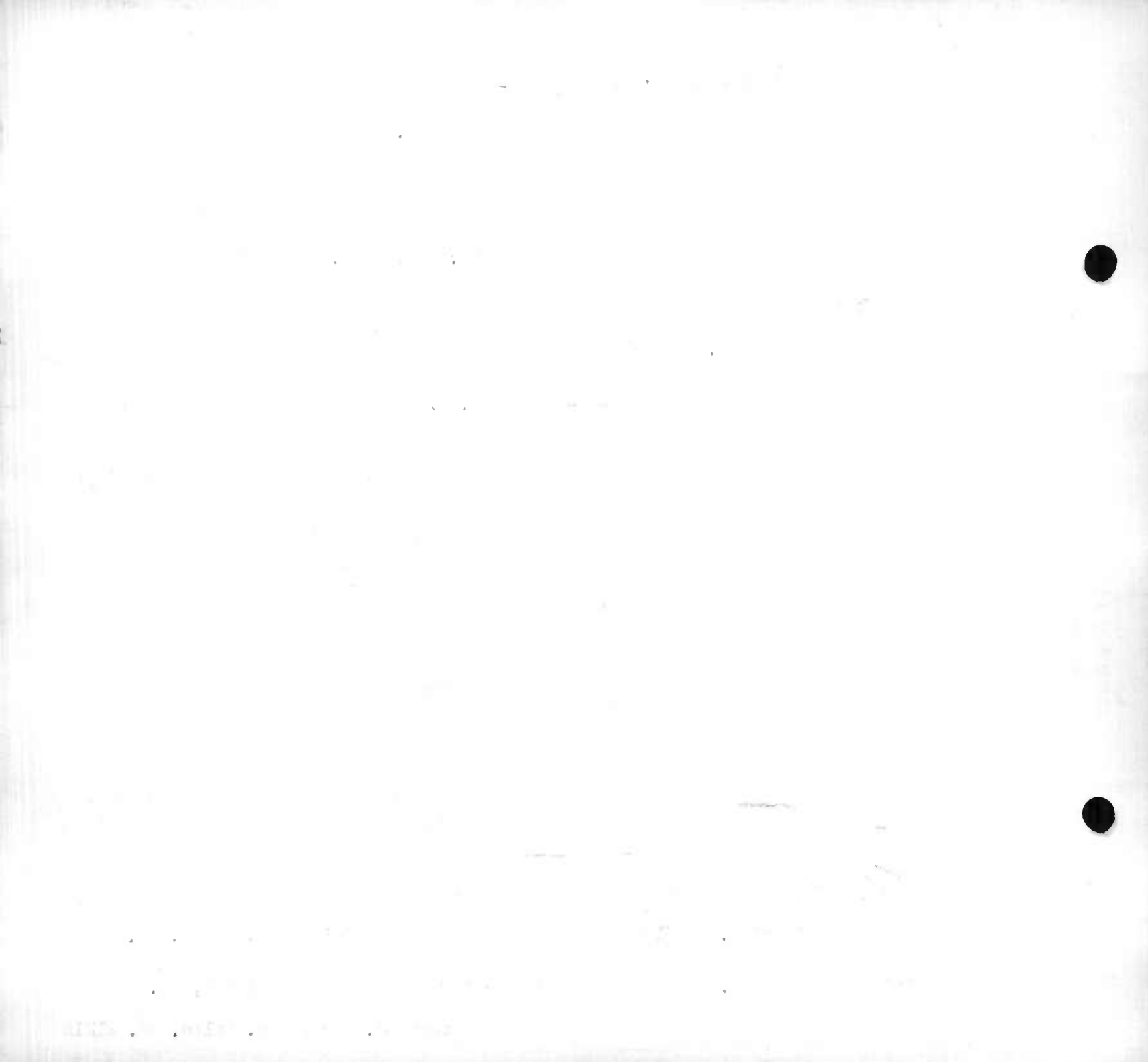
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3581	
CERTIFICATE OF DEATH					
BIRTH NO. K-514		1. NAME OF DECEASED (Type or Print) EDNA MAY KNOBLOCK		2. DATE AND HOUR OF DEATH April 1, 1970 11:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Broadview Apts #1009 116 W. University Pkwy			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1201		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 116 W. University Pkwy		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1886.	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME George Knoblock		
14. MOTHER'S MAIDEN NAME Victoria Roth			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-44-2319		17. INFORMANT ADDRESS Mrs. A. Maude Boettinger (Same)			
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GI bleeding ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Lymphatic Leukemia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hepes Zoster					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 19 67 to 4-1 19 70 , that (I) (we) last saw the deceased alive on 4-1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE E. Hunter Wilson Jr M.D.			23B. DATE SIGNED 4-1-70		23C. PHYSICIAN'S NAME (Type) Dr. Hunter Wilson
23D. ADDRESS Medical Arts Bldg. Balto. Md.			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 4/4/70.		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc., Balto. Md 21214	



FUNERAL DIRECTOR: IMPORTANT

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H-616 70 3582		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3582	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARIE M. HERBERT		2. DATE AND HOUR OF DEATH 4/1/70 1:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Md. B. COUNTY		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 4110 Moravia Road	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1899	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George J. Herbert		14. MOTHER'S MAIDEN NAME Anna Streb	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-36-8270		17. INFORMANT Mr. C. Earl Button	
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE CONGESTIVE HEART FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ANEMIA UREMIA BENIGN NEPHROSCLEROSIS		(B) DUE TO, OR AS A CONSEQUENCE OF: MULTIPLE MYOCARDIAL INFARCTIONS		Years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ANEMIA UREMIA BENIGN NEPHROSCLEROSIS		(C) DUE TO, OR AS A CONSEQUENCE OF: MULTIPLE MYOCARDIAL INFARCTIONS		Years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 3/31/1970 to 4/1/1970 that (I) (we) last saw the deceased alive on 3/31/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 4/1/70	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley				23D. ADDRESS 4900 Belair Road, Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/6/70.		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME of REGISTRAR Robert E. ...	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

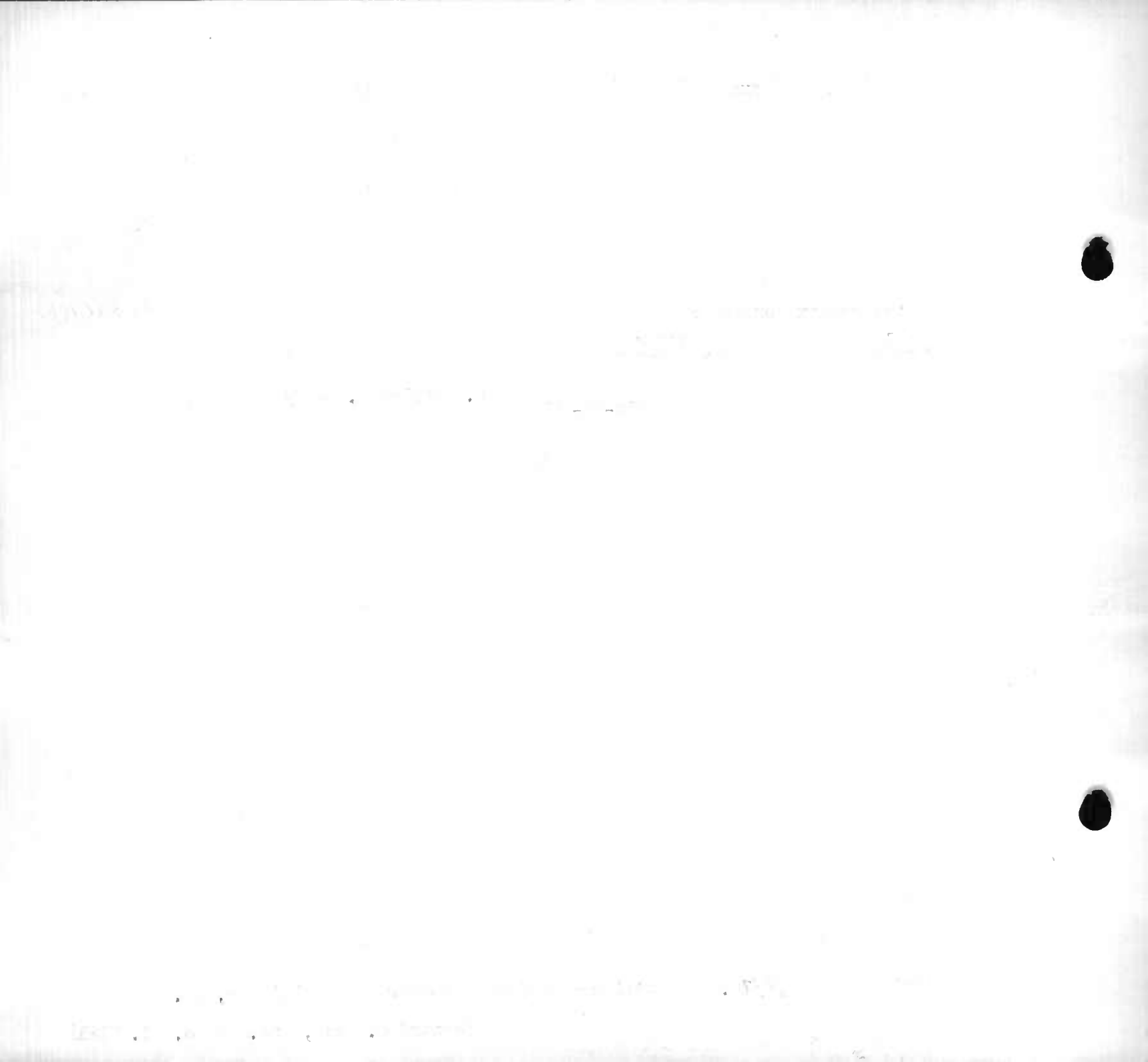
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<div style="display: flex; justify-content: space-between;"> 8-251 70 3583 </div>		<div style="display: flex; justify-content: space-between;"> BALTIMORE CITY HEALTH DEPARTMENT 70 3583 </div>	
BIRTH NO. REG. NO.		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) REISENWEBER; JOHN HERBERT		2. DATE AND HOUR OF DEATH 4/1/70 2:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2633 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3243 DUDLEY AVE.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/28/05 9. AGE (In years last birthday) 64 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Die Maker		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN REISENWEBER		14. MOTHER'S MAIDEN NAME SADIE SCHNEIDER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-6827	
17. INFORMANT MRS KATHERINE REISENWEBER (Same)		ADDRESS	
18. 441.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac tamponade ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ruptured dissecting aneurysm of thoracic aorta		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. DATE OF OPERATION 2		20. AUTOPT? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 3/29 19 70 to 4/1 19 70 that (I) (we) last saw the deceased alive on 4/1 19 70 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Anne L. Leddy M.D.	
23B. DATE SIGNED 4/1/70		23C. PHYSICIAN'S NAME (Typal) Anne L. Leddy M.D.	
23D. ADDRESS Union Memorial Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 4/4/70		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 6 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

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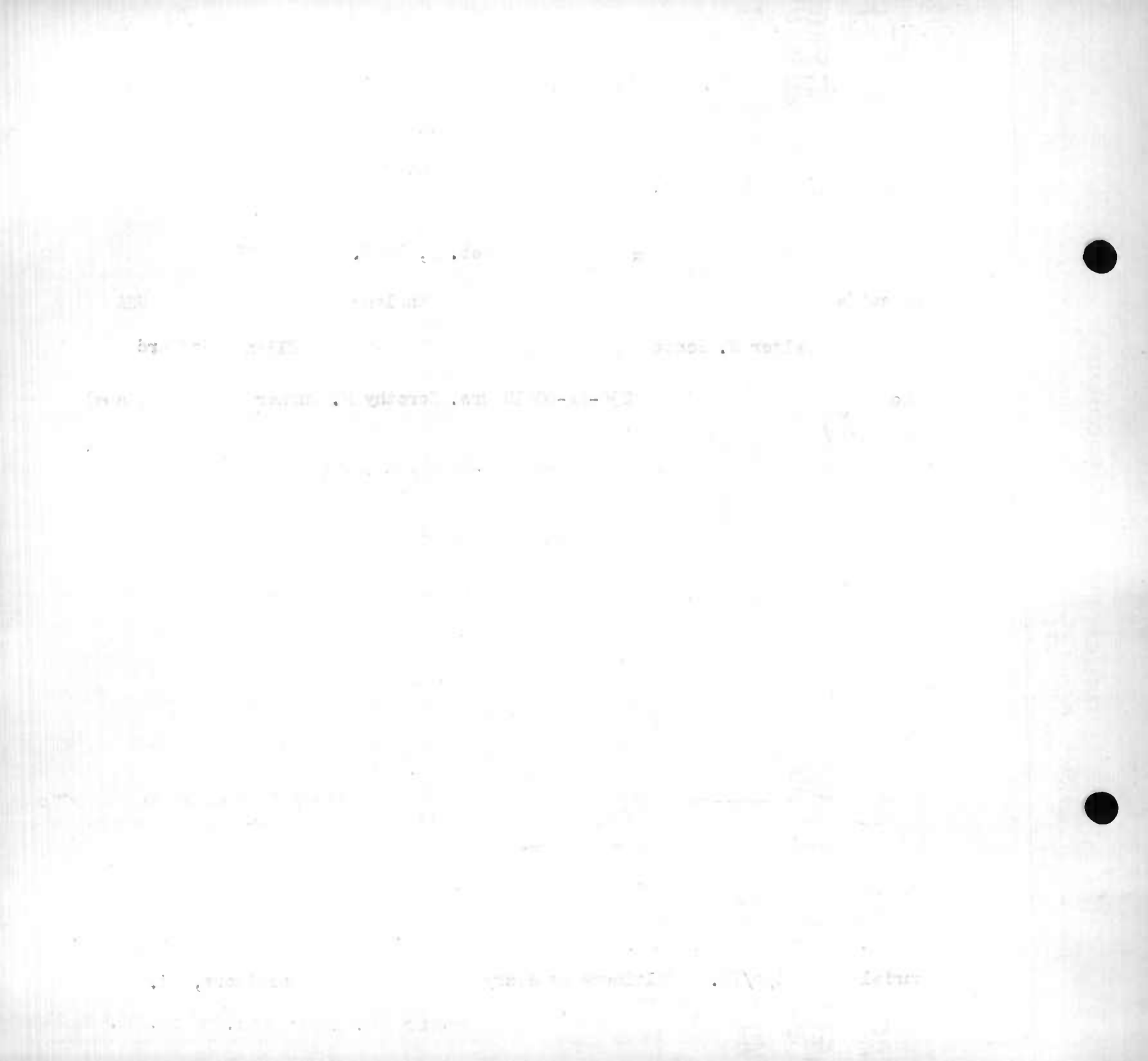
L-300 70 3584				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3584	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Print or Print) ANNA PAULINE LEEDY				2. DATE AND HOUR OF DEATH 04-1-70 7,25 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY U.S.A.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE UNION MEMORIAL HOSPITAL.				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 06-14-89		9. AGE (In years lost birthday) 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME MARTIN RAUSER				14. MOTHER'S MAIDEN NAME MARY LANG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 216-46-4715		17. INFORMANT Mr. Charles R. Leedy HUSBAND	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO RESPIRATORY ARREST. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRO VASCULAR ACCIDENT UREMIA				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 03-30 19 70 to 04-01- 19 70 that (I) (we) last saw the deceased alive on 04-01- 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Yasumasa Yamasaki M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 04-01-70	
23C. PHYSICIAN'S NAME (Type) YASUMASA YAMASAKI M.D.				23D. ADDRESS 33RD AND CALVERT STS BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/6/70.		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Blair Kelly		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
B-423		70	3585	70 3585	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
OLIVE E. BLACKSTOCK		March 31, 1970		3:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 5723 Willowton Ave.			A. STATE Maryland		
			B. COUNTY 2758		
FULL NAME OF HOSPITAL OR INSTITUTION 5723 Willowton Ave.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 5723 Willowton Ave.		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1895.	9. AGE (In years last birthday) 75	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter E. Scott		14. MOTHER'S MAIDEN NAME Ellen Goddard	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 236-12-0081D		17. INFORMANT Mrs. Dorothy M. Turner	
				ADDRESS (Same)	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary occlusion</u> (B) <u>Autosomal C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1969</u> to <u>March 31</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>March 16</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Henry Haase M.D.</u>				23B. DATE SIGNED <u>4/1/70</u>	
23C. PHYSICIAN'S NAME (Type) Dr. Henry Haase, M.D.				23D. ADDRESS 2926 E. Cold Spring Lane, Balto. Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/4/70.		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR <u>Robert E. Kelly, Jr.</u>		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214	
25D. ADDRESS 21214					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-656 70 3586		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3586	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
JOHN M. WOERNER Woerner		April 2, 1970. 6:45 A.M.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
00 6208 The Alameda		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2738		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct. 21, 1919		9. AGE (In years last birthday) 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Woerner	
14. MOTHER'S MAIDEN NAME Sophia J Austin		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 220-03-1948	
17. INFORMANT Carlyn E Woerner		ADDRESS 2/2/2		18. CAUSE OF DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410.9 + 1250.9 Myocardial Infarct minutes		Chronic Coronary Disease 10 yrs		Diabetes Mellitus years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1966 to April 2, 1970, that (I) (we) last saw the deceased alive on March 31, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William P. Benson, Jr., M.D.		23B. DATE SIGNED April 2, 1970		23C. PHYSICIAN'S NAME (Type) WILLIAM P. BENSON, JR. M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/6/70		24C. NAME OF CEMETERY or CREMATORY Baltimore, National	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR Robert E. Fisher, M.D.	
24G. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		24H. ADDRESS		24I. DATE	

1952 2000

1952 2000

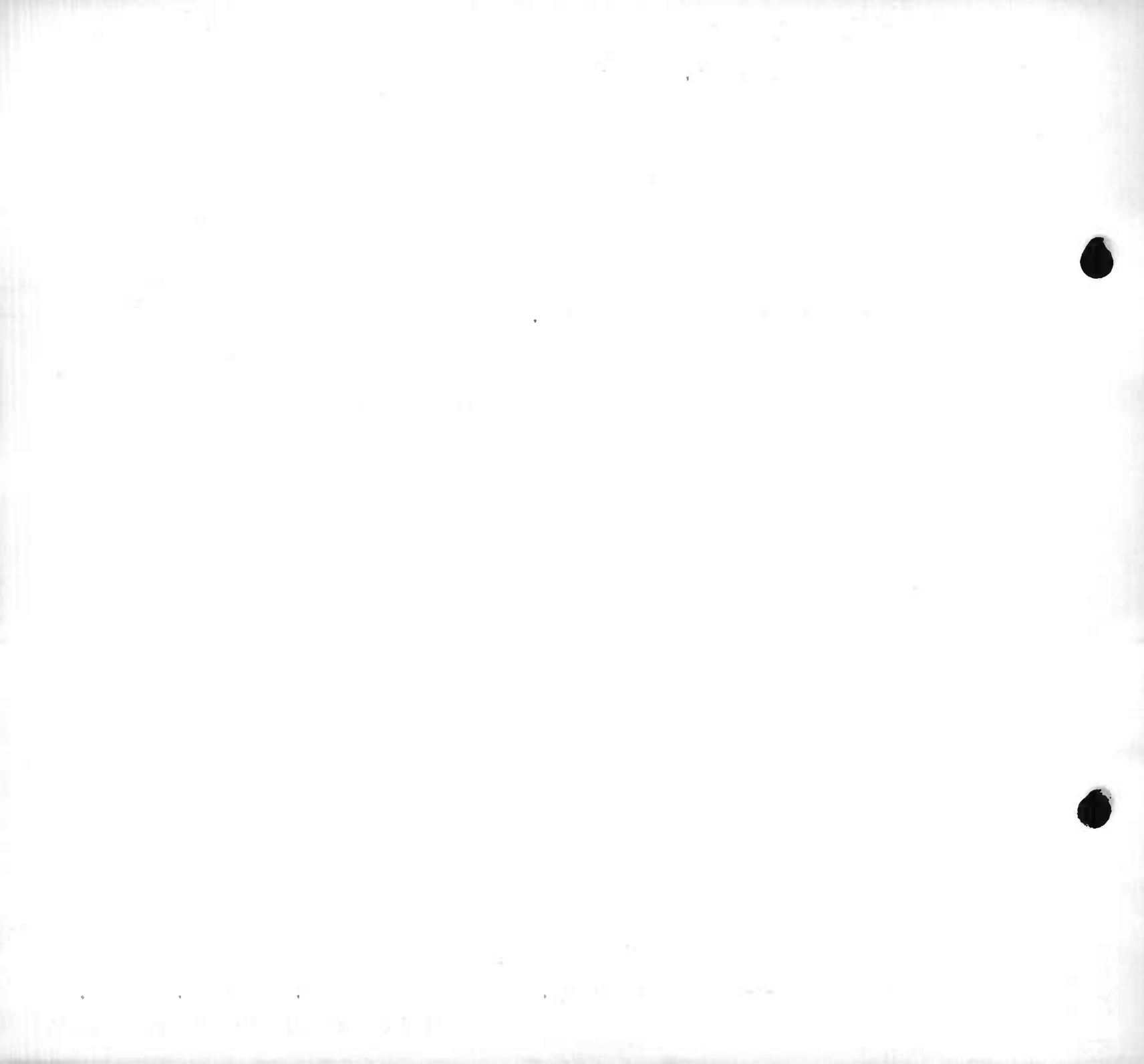
1952 2000

1952 2000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3587	
BIRTH NO. M-360 70 3587		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Louise Augusta Meedter		2. DATE AND HOUR OF DEATH 4-2-70 5:55 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY —	
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-7-97 9. AGE (in years last birthday) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10B. KIND OF BUSINESS OR INDUSTRY Warrington Apts.	
11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY O. SCHUE		14. MOTHER'S MAIDEN NAME ELIZABETH SCHUE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-1862A	
17. INFORMANT Howard C Kiel		ADDRESS 3109 Glendale Ave 21234	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CEREBROVASCULAR ACCIDENT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/17 19 70 to 4-2 19 70 that (I) (we) last saw the deceased alive on 4-2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE William Eric Sohre, M.D.		23B. DATE SIGNED 4-2-70	
23C. PHYSICIAN'S NAME (Type) WILLIAM ERIC SOHRE, M.D.		23D. ADDRESS 4402 COLBOURNE RD. BALTO. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-6-70	
24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		24D. LOCATION (City, town, or county) (State) Balto. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Vahley, M.D.	
25C. FUNERAL DIRECTOR Leonard J Ruck Inc		ADDRESS 5305 Harford Rd 21214	



DR. MC HOLD

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

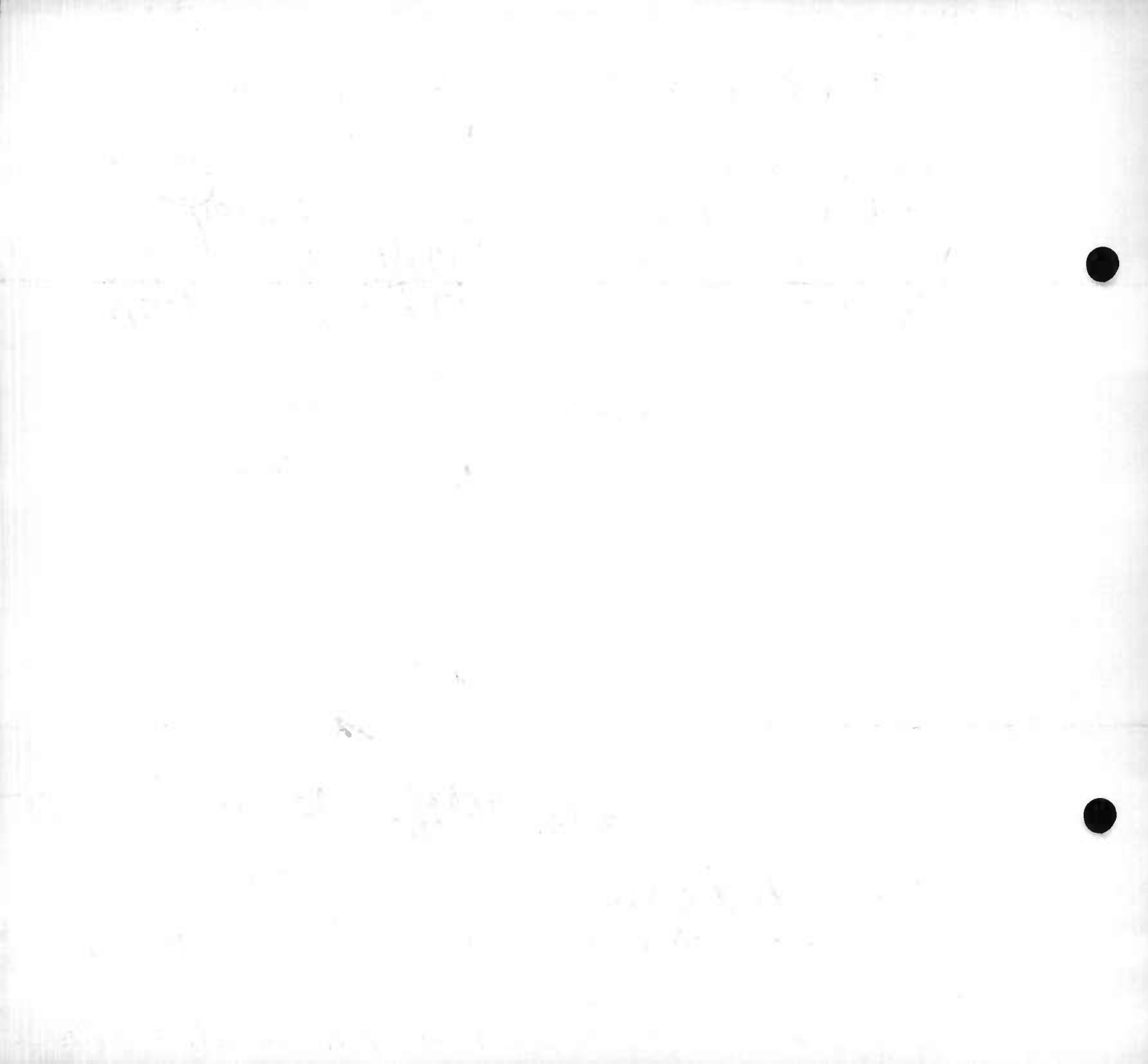
B-322 70 3588		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3588	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		STANLEY P. RADGOWSKI		3.30.70 740 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY	
THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
33		E. STREET AND NUMBER 713 S. BOND ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-45	9. AGE (In years last birthday) 24	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN RADGOWSKI		14. MOTHER'S MAIDEN NAME MARY KACZYNSKI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES ARMY		16. SOCIAL SECURITY NO. 212-44-4829		17. INFORMANT MRS. MARY RADGOWSKI	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 486 X-1 303.9		CAUSE OF DEATH PROBABLE SEPTICEMIA WITH SHOCK (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) POSSIBLE MASSIVE ASPIRATION DUE TO, OR AS A CONSEQUENCE OF: (C) PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). NARCOTICS, ALCOHOL ABUSE					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3.30 19 70 to 3.30 19 70, that (I) lost saw the deceased alive on 3.30 19 70 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE J. SYLVESTER				23B. DATE SIGNED 3.30.70	
23C. PHYSICIAN'S NAME (Type) J. SYLVESTER		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/3/1970		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NAT'L CEM.	
24D. LOCATION BALTIMORE MD.		24E. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		24F. ADDRESS 2525 FLEET ST.	

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2 4 10 00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

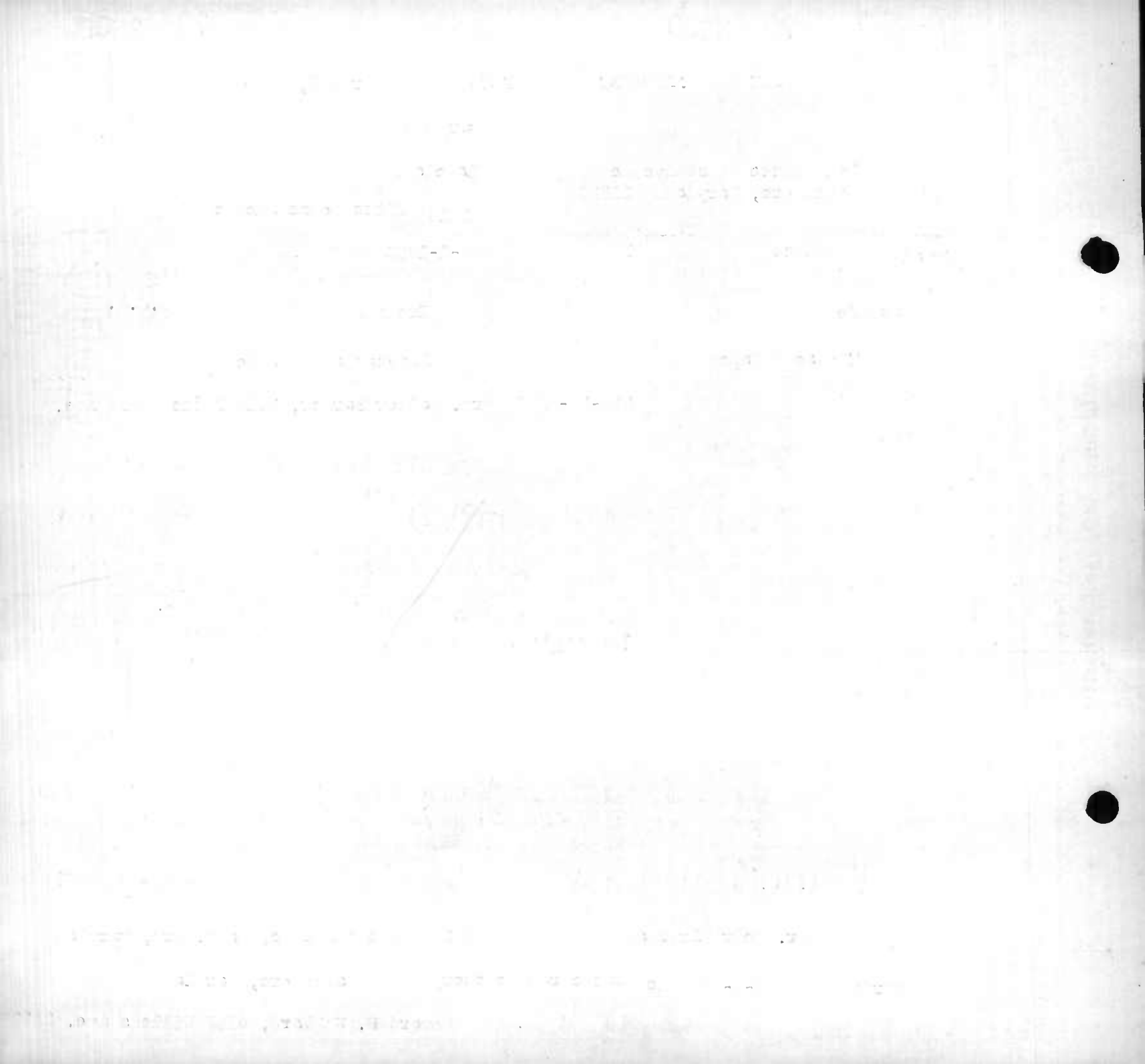
N-616 70 3589		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3589	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) HERESA D. NOPBERG			2. DATE AND HOUR OF DEATH 4/1/70 12:05 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Mem Hosp			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTO		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Mem Hosp			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX F			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6/24/96			9. AGE (In years last birthday) 73		10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASUR			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 219-12-9605			17. INFORMANT CHAR ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANSCVD, CHF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/31 19 70 to 4/1 19 70 and that (I) (we) last saw the deceased alive on 3/31 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harvey B. Stuber			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) HARVEY B. STUBER MD
23D. ADDRESS Union Mem. Hosp.			24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		
24B. DATE 4/4/70			24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM.		
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.			25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, MD.			25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI		
25D. ADDRESS 2525 FLEET ST.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

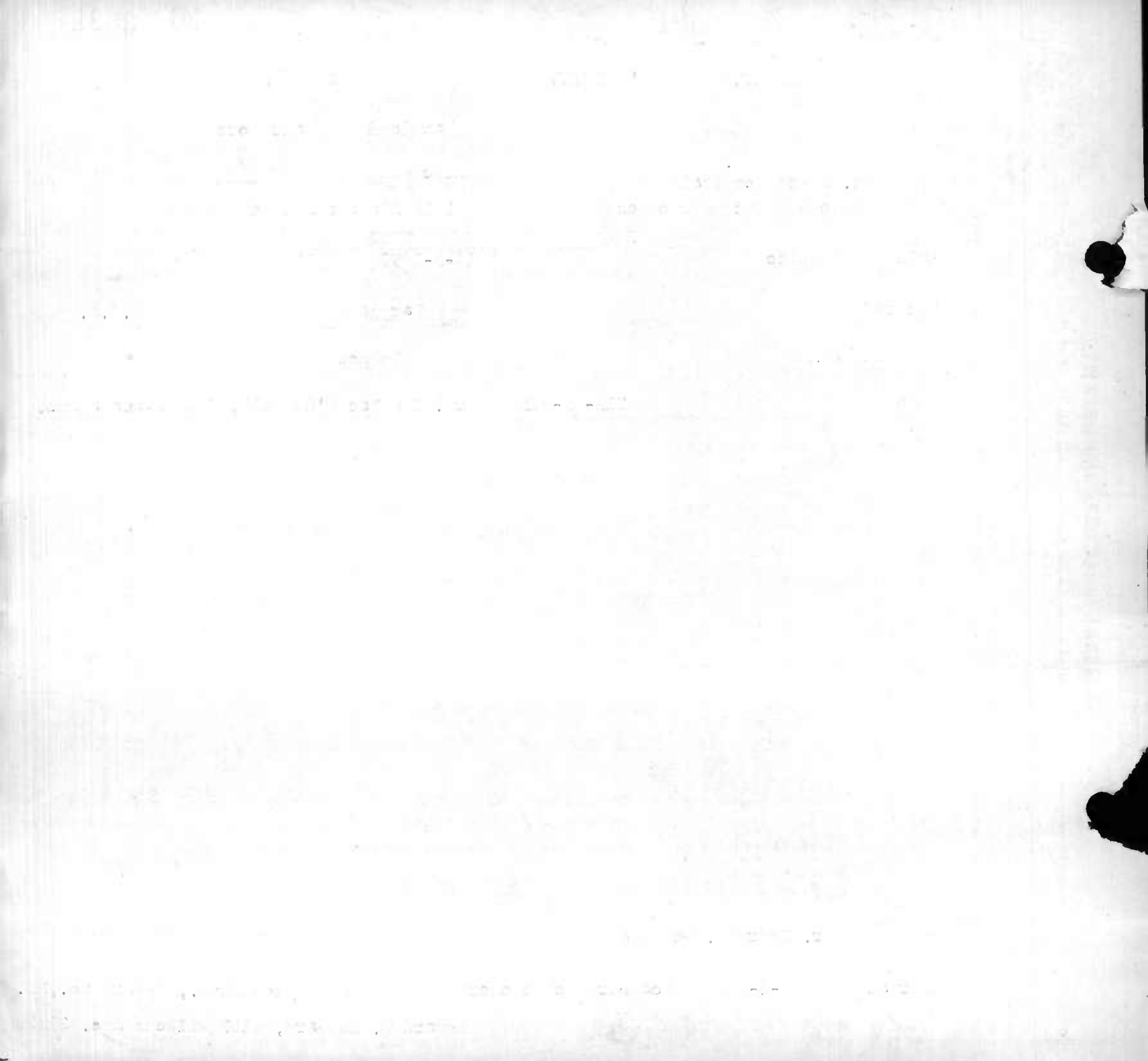
Baltimore City Health Department				REG. NO. 70 3590	
7-450 70 3590		BIRTH NO. 70 3590			
1. NAME OF DECEASED (Type or Print) MARY MARGARET FLYNN			2. DATE AND HOUR OF DEATH April 1, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2610 Rittenhouse Avenue Baltimore, Maryland 21230			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2572 C. CITY OR TOWN Lakeland D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2610 Rittenhouse Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-1-1890	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Thomas Hayes		
14. MOTHER'S MAIDEN NAME Anastasia Nagle			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214-20-4586			17. INFORMANT Mrs. Walter Parker, 2610 Rittenhouse Ave.		
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410.0 ACUTE coronary occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HCDV II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Myocardial heart disease with failure. Coronary heart disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years years years		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 31 1970 to March 31 1970 that (I) (we) last saw the deceased alive on March 31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry Armanas			23B. DATE SIGNED April 3, 1970		23C. PHYSICIAN'S NAME (Type) Dr. Henry Armanas
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4-4-70		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

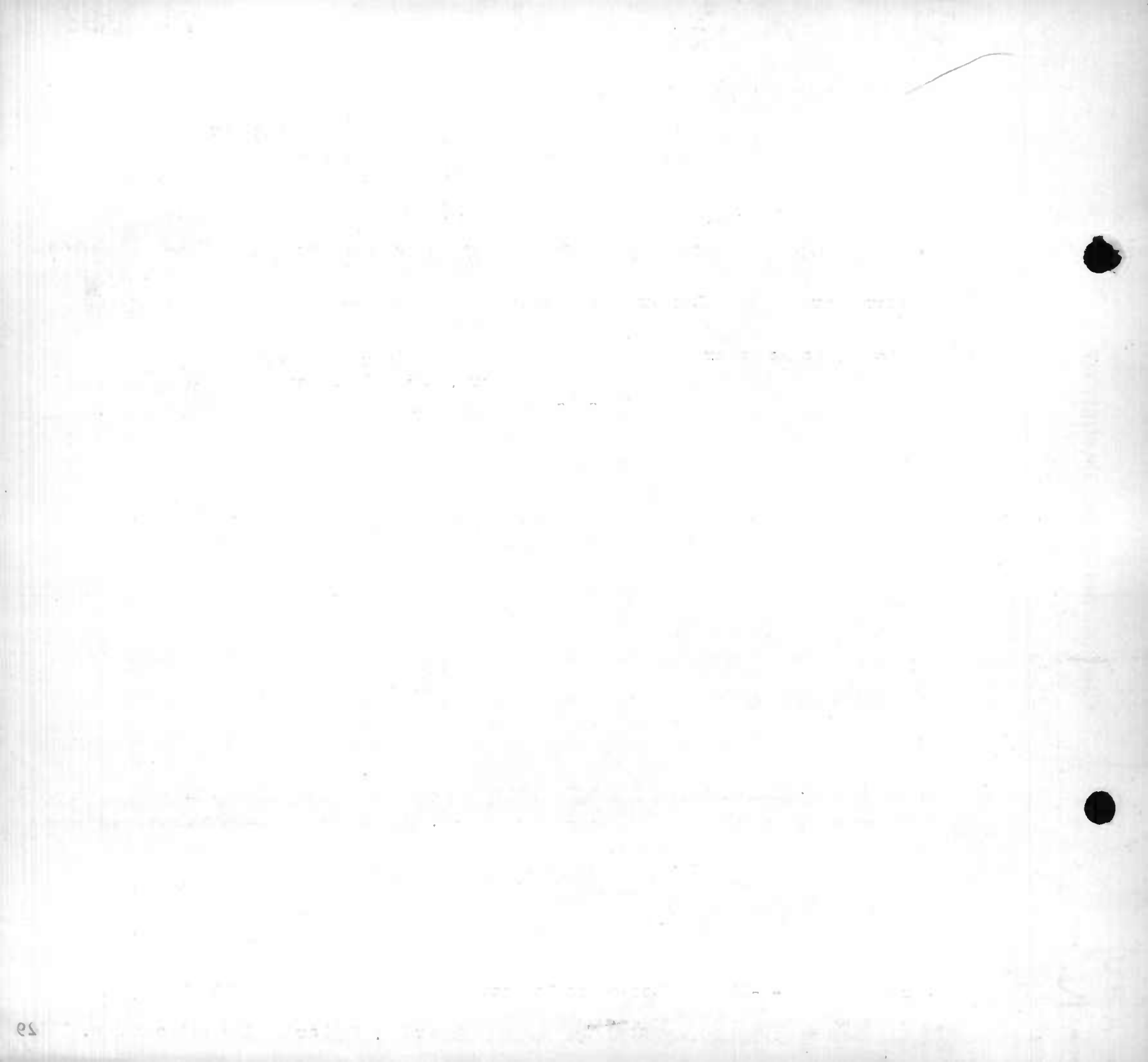
BIRTH NO. 70 3591			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
SAMUEL O'CONNELL		April 1, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Wilkins & Catons Avenues		A. STATE B. COUNTY Maryland Baltimore 5300	
C. CITY OR TOWN Rosemont		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2815 Alabama Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-1897
		9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-9156	
		17. INFORMANT Mrs. Ida Mae O'Connell, 2815 Alabama Ave.	
		ADDRESS 21227	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH CVA Ca of pancreas	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-31 1970 to 3-31 1970, that (I) (we) last saw the deceased alive on 3-31 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Pedro S. DeBorja		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Dr. Pedro S. DeBorja		23D. ADDRESS 1020 Amistad Way Balt 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-4-70	
24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Washington Blvd., Howard Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Howard H. Hubbard	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkins Ave. 21229		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

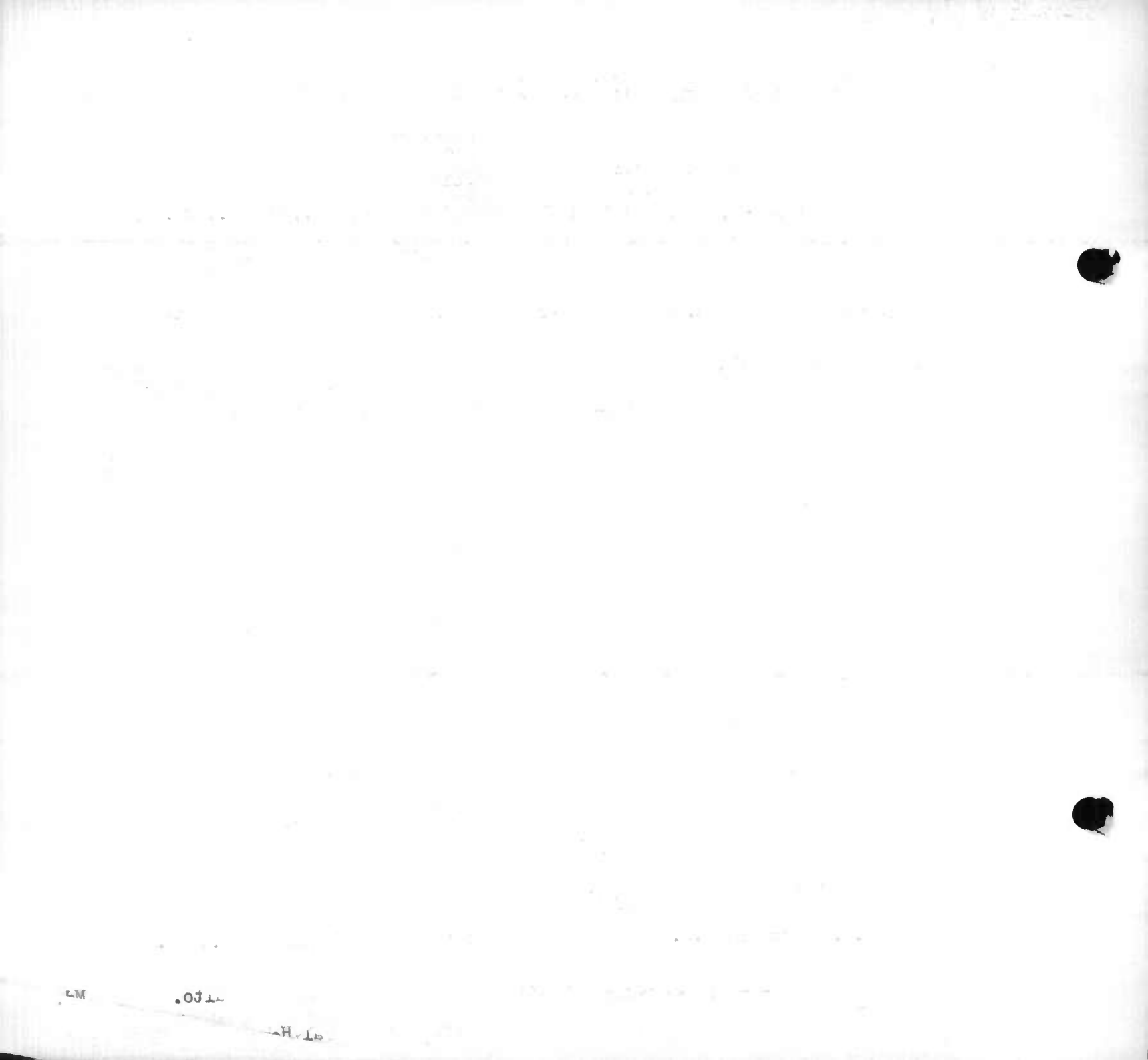
<p>S-230 70 3592</p> <p>BIRTH NO.</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 70 3592</p>	
<p>1. NAME OF DECEASED (Type or Print) <u>Swigaett, Caroline D.</u></p>			<p>2. DATE AND HOUR OF DEATH <u>4-1-70 9:50 A.M.</u></p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital</u></p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Woodlawn</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1137 Dorchester Avenue</u></p>		
<p>5. SEX <u>7</u></p>	<p>6. RACE <u>W.</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>92 11-25-77</u></p>	<p>9. AGE (In years last birthday) <u>77</u></p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dietary Work</u></p>
<p>10B. KIND OF BUSINESS OR INDUSTRY <u>Lutheran Hospital</u></p>			<p>11. BIRTHPLACE (State or foreign country) <u>Delaware</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u></p>
<p>13. FATHER'S NAME <u>John Dannenhauer</u></p>			<p>14. MOTHER'S MAIDEN NAME <u>Laur Scott</u></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>213-01-7556</u></p>	<p>17. INFORMANT <u>Mrs. Lillian Bailey</u> ADDRESS <u>BALTIMORE 21207</u> <u>Daughter</u> <u>1137 Dorchester Ave.</u></p>		
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthemia, etc. It means the disease, injury or complication which caused death.) <u>154.1 I</u></p>			<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Rectum</u> (B) <u>Diffused Carcinomatosis.</u> (C) _____</p>		
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Asthemia,</u></p>			<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>		
<p>19A. DATE OF OPERATION <u>2</u></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p>		<p>20A. AUTOPSY? (Yes or No) <u>YES</u></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>	<p>21C. WHERE DID INJURY OCCUR? _____</p>		
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? _____</p>		
<p>22. I certify that (I) (this hospital) attended the deceased from <u>2-28</u> 19<u>70</u> to <u>4-1-</u> 19<u>70</u>, that (I) (we) last saw the deceased alive on <u>4-1-</u> 19<u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Rajinder P. Gandhi</u></p>			<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>	<p>23B. DATE SIGNED <u>3 4/1/70</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>RAJINDER PAL GANDHI</u></p>			<p>23D. ADDRESS <u>730 ASHBURTON ST. BALTIMORE, MD. 21216</u></p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>24B. DATE <u>4-4-1970</u></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u></p>	<p>24D. LOCATION (City, town, or county) (State) <u>Snow Hill, Maryland</u></p>		
<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1970</u></p>			<p>25B. NAME OF REGISTRAR <u>Robert E. Hubbard</u></p>		
<p>25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u></p>			<p>ADDRESS <u>4107 Wilkens Ave. 21229</u></p>		



FUNERAL DIRECTOR: IMPORTANT

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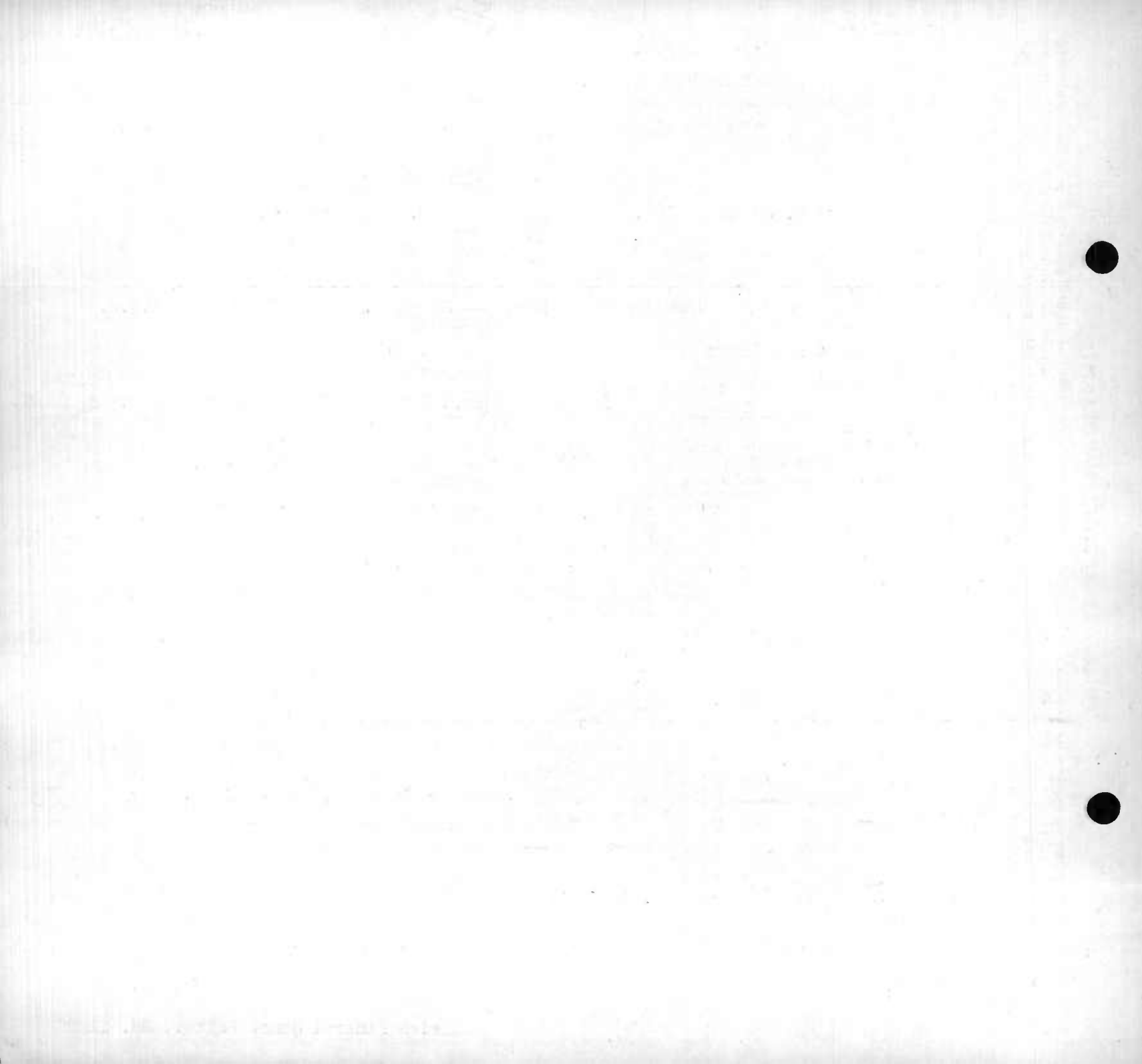
55-77-01 1s		70 3593		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3593	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GREENFIELD, John David				2. DATE AND HOUR OF DEATH 3/31 3:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY Balto. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 9645 Dundawan Rd., Balto., Md. 21236					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-33	9. AGE (In years last birthday) 36	If Under 1 Yr. Months: Days: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? United States		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman			10B. KIND OF BUSINESS OR INDUSTRY E.R. Squibb & Sons		11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Harry Greenfield				14. MOTHER'S MAIDEN NAME Mary Lyden					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 207-26-6040		17. INFORMANT BCH Records: Baltimore, Maryland 21224 ADDRESS 4940 Eastern Avenue					
18. 201X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Hodgkin Dis - TD 13 DUE TO, OR AS A CONSEQUENCE OF: 1 1/2 yrs (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Anemia, pneumonia, pleural effusion, hypercalcemia, aplasia, hematemesis 20									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3/17 19 70 to 3/31 19 70 that (I) (we) last saw the deceased alive on 3-30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. S. Atkinson, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/31/70			
23C. PHYSICIAN'S NAME (Type) J.S. Atkinson, M.D.		23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave., Balto., Md. 21224							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-3-1970		24C. NAME of CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Fullerton Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Road			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3594	
<div style="font-size: 1.5em; font-weight: bold;">H-552</div> <div style="font-size: 1.5em; font-weight: bold;">70 3594</div>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. M.	
EDWARD HENNINGER, JR.		April 3, 1970		3:00	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md. B. COUNTY			
00 429 N. Highland Ave.		C. CITY OR TOWN D. INSIDE CITY LIMITS?			
		Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER		429 N. Highland Ave.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 24, 1903	66	11. If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Security Guard		Venetian Blind Mfr.		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edward Henninger		Jennie Black		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		220-07-2022		Mrs. Irene Marie Henninger, 429 N. Highland. 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
151.9 I		ASTROIC HEMMORRHALE FROM			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CARCINOMA OF STOMACH			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		WITH METASTASIS TO LEFT LUNG			
		(C)			
II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		DEC-3-69			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None		None		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
None		None		None	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
None		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		None	
22. I certify that (I) (the hospital) attended the deceased from DEC 3 1969 to APR 3 1970, that (I) last saw the deceased alive on FEB 23 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E. G. Schinunek MD.				4-4-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Emmanuel A. Schinunek, MD.				842 S. East Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
burial		4-6-70		Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 6 1970		Robert E. Taylor, R.D.		Ullrich Funeral Home, Balto., Md. 21206	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) NATHAN E. THOMAS				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> April 2 1970 1:00 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1937 Ridgehill Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour April 2 1970 1:00 p.m.			
6. SEX 7. RACE 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Male Negro WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland 1504			
9. DATE OF BIRTH 1-26-52 10. AGE (In years lost birthday) 18 11. BIRTHPLACE (State or foreign country) Maryland				C. CITY OR TOWN D. INSIDE CITY LIMITS? Balto. YES <input type="checkbox"/> NO <input type="checkbox"/>			
12. CITIZEN OF WHAT COUNTRY? Maryland				E. STREET AND NUMBER 1937 Ridgehill Ave.			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				13. FATHER'S NAME Nathan Thomas			
14B. KIND OF BUSINESS OR INDUSTRY				15. MOTHER'S MAIDEN NAME Geraldine			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service)				17. SOCIAL SECURITY NO.			
18. INFORMANT Mrs. Geraldine Thomas				ADDRESS 1937 Ridgehill Ave			
19. 304.9 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intravenous narcotism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 2							
21. AUTOPSY? (Yes or No) YES							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Isidore Mihalakis</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Isidore Mihalakis ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: 4/3/70 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-7-70		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Isidore Mihalakis		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.			

1-20-32

Marjane

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4-7-70

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Marjane

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

3596

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary E. Fisher

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospitals

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

4

3

70

3:05 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore 5300

6. SEX

female

7. RACE

colored

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1-29-12

10. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

16 King Ave.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Edward Jordon

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Margaret Newby

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mr. Wilder E. Fisher 16 King Ave.

19.

398X

I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Rheumatic heart disease
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Arteriosclerotic cardiovascular disease

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

4/4/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/8/70

24C. NAME OF CEMETERY or CREMATORY

Carver Mem. Park

24D. LOCATION (City, town, or county)

Laurel, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 6 1970

Wm C March 928 E. North Ave.

1-29-18

Alphons

Edward London

University of

Dr. Edward E. London is Vice

VALLEY

PRO-COUNT

AT ALPHONS

Edward London

University of

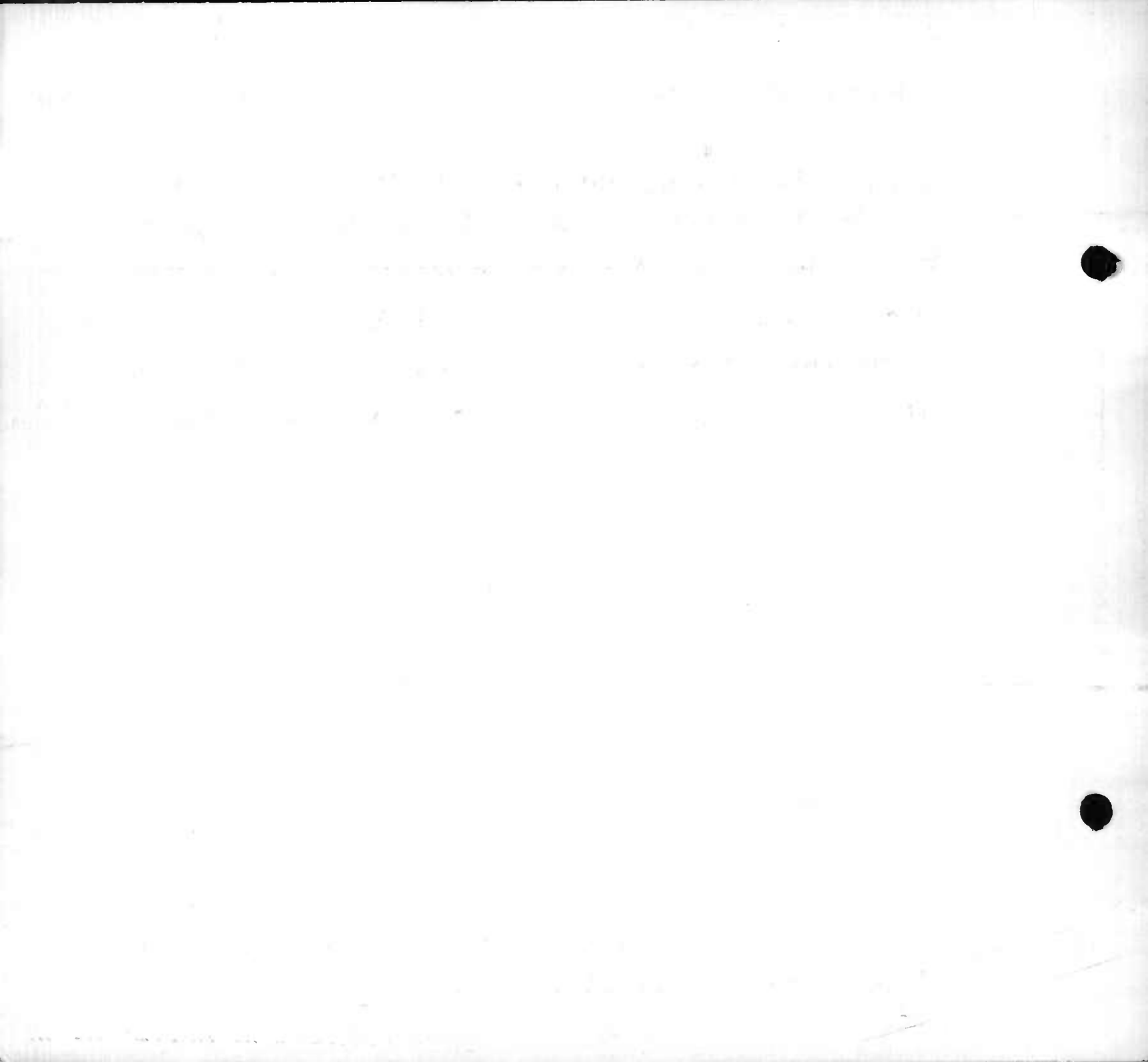
Alphons

Dr. Edward E. London is Vice

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-200 70 3597		BALTIMORE CITY HEALTH DEPARTMENT		70 3597	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) FRANCES E. WISE			2. DATE AND HOUR OF DEATH 4-2-70 12:55 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1207		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital 44 33rd + CALVERT STS			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2706 MILES AVE.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-01	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME WILLIAM KOERBER		
14. MOTHER'S MAIDEN NAME FRANCES WOODS			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 216-12-9624			17. INFORMANT Union Memorial		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 250.9 1			CAUSE OF DEATH (A) IMMEDIATE CAUSE ASCVD DUE TO, OR AS A CONSEQUENCE OF: (B) DIABETIC DUE TO, OR AS A CONSEQUENCE OF: (C) MYOCARDIAL INFARCTION		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Tetsuo Tagawa			23B. DATE SIGNED 4-2-70		
23C. PHYSICIAN'S NAME (Type) Tetsuo Tagawa			23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/6-70		
24C. NAME OF CEMETERY OR CREMATORY Baltimore National			24D. LOCATION (City, town, or county) (State) Baltimore Md		
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970			25B. NAME OF REGISTRAR Robert E. Taylor, MD.		
25C. FUNERAL DIRECTOR Frank H. S. 814 W 36th St Md			ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. <u>70 3598</u>	
BIRTH NO. <u>K-400 70 3598</u>		DATE AND HOUR OF DEATH <u>APRIL 1, 1970</u> <u>6:15 P.</u> M.	
1. NAME OF DECEASED (Type or Print) <u>KELLY, MARTHA</u>		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST AGNES HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE COUNTY</u> <u>5300</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>1105 NEWFIELD ROAD</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 27 89</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE (In years last birthday) <u>80</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>RALPH HEWITT</u>		14. MOTHER'S MAIDEN NAME <u>ISABELLE O'BRIEN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ST AGNES RECORDS-BALTO MD</u>		ADDRESS <u>21229</u>	
18. <u>199.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Generalized Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (B) <u>Congestive Heart Failure 2° to</u> DUE TO, OR AS A CONSEQUENCE OF <u>chronic heart disease</u> (C) <u>—</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 10</u> 19 <u>70</u> to <u>APRIL 1</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>APRIL 1</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Ruben V. Luna M.D.</u>		23B. DATE SIGNED <u>04 01 70</u>	
23C. PHYSICIAN'S NAME (Type) <u>RUBEN V LUNA M.D.</u>		23D. ADDRESS <u>ST AGNES HOSPITAL CATN & WILKENS AVE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-4-70</u>	
24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>	
25C. FUNERAL DIRECTOR <u>Farley Canavan F.H.</u>		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3599	
L-220 70 3599		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Annie (Anna) M. Leikus		2. DATE AND HOUR OF DEATH 4/1/70		7:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2744			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5928 Glenoak Ave.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/1884	9. AGE (In years lost birthday) 85	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Lithuania	
12. CITIZEN OF WHAT COUNTRY? Lithuania		13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-12-4984		17. INFORMANT Mrs. Mary Werner - 5928 Glenoak Ave.			
18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary insufficiency		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive CVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1959 to April 1, 1970 , that (I) was last saw the deceased alive on September 19, 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE R. Donald Jandorf		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/2/70	
23C. PHYSICIAN'S NAME (Type) R. Donald Jandorf, M.D.		23D. ADDRESS 7403 Harford Rd. - Balto., Md. 21234			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/4/70	24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert C. Altenburg		FURNERAL DIRECTOR ADDRESS 6009 Harford Rd. - Balto., Md. 21214	

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3600

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN J. LEYDEN

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

March 31, 1970

6:05 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE ?

B. COUNTY

00-00

00 Rear 2557 Frederick Ave. (Junk Yard)

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

?

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

6/1/1913

10. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.

Months

Days

Hours

Min.

E. STREET AND NUMBER

?

11. BIRTHPLACE (State or foreign country)

Philadelphia, Penna.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Leyden

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cook

14B. KIND OF BUSINESS OR INDUSTRY

Restaurant

15. MOTHER'S MAIDEN NAME

Mary Manley

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

167-18-0131

18. INFORMANT

Hollen Funeral Home-728 E. Allegheny A

ADDRESS
Phila., Penna.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/1/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

24B. DATE

4/2/70

24C. NAME of CEMETERY or CREMATORY

Holy Sepulchre Cem.

24D. LOCATION (City, town, or county) (State)

Montgomery Co., Pennsylvania

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 6 1970

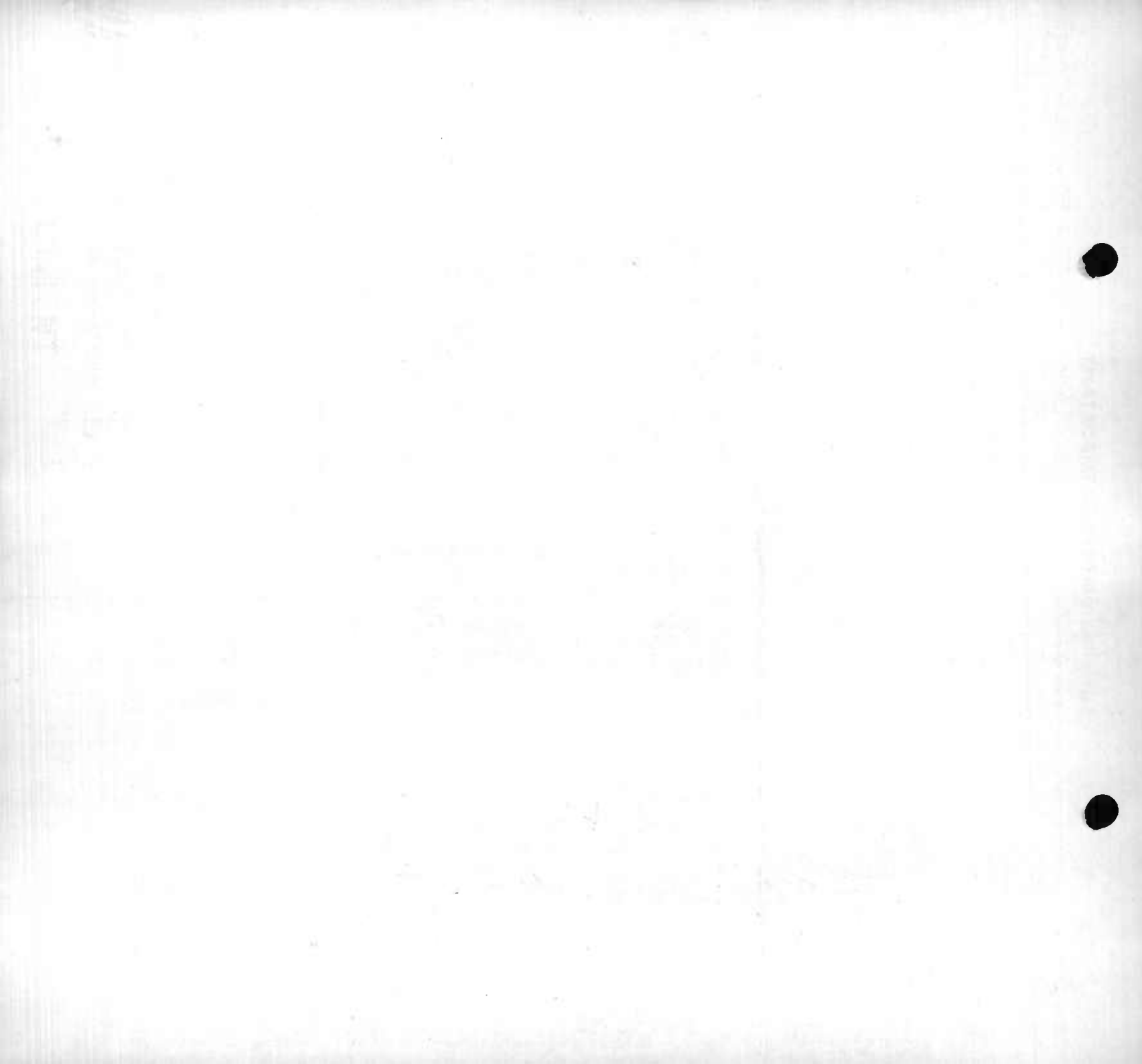
25B. NAME OF REGISTRAR
25C. FUNERAL DIRECTOR
25D. ADDRESSRobert C. Altenburg Funeral Home, Inc.
6009 Harford Rd. - Balto., Md. 21214



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

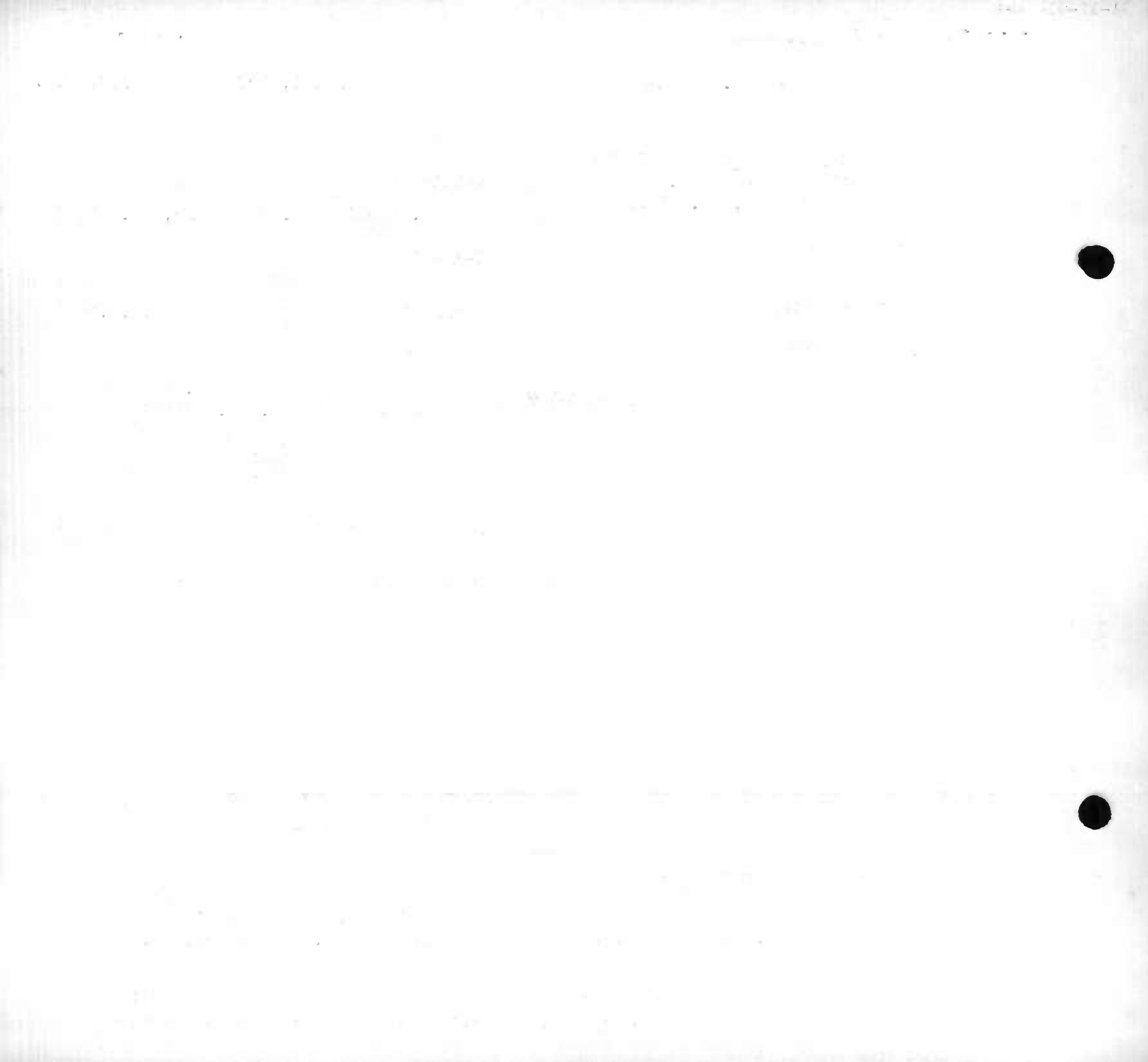
F-623		70 3601		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3601	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Johanna A. Forrester</i>			
2. DATE AND HOUR OF DEATH <i>4/1/70</i>				7:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>901</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>909 Andover Rd</i>				E. STREET AND NUMBER <i>909 Andover Rd</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/15/87</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Carl Albers</i>				14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-50-7093</i>		17. INFORMANT <i>Magdalena Miller</i>		ADDRESS <i>909 Andover Rd</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Chronic Cardiovascular Disease</i> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Hypothyroidism</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>1950</i> 19 to <i>Apr. 1</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>April 31</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED <i>4/2/70</i>		23C. PHYSICIAN'S NAME (Type) <i>D. Roy M. Zimmerman M.D.</i>	
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/3/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 6 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Ambrose I. De. 132 S. Sulphur Sp. Rd</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

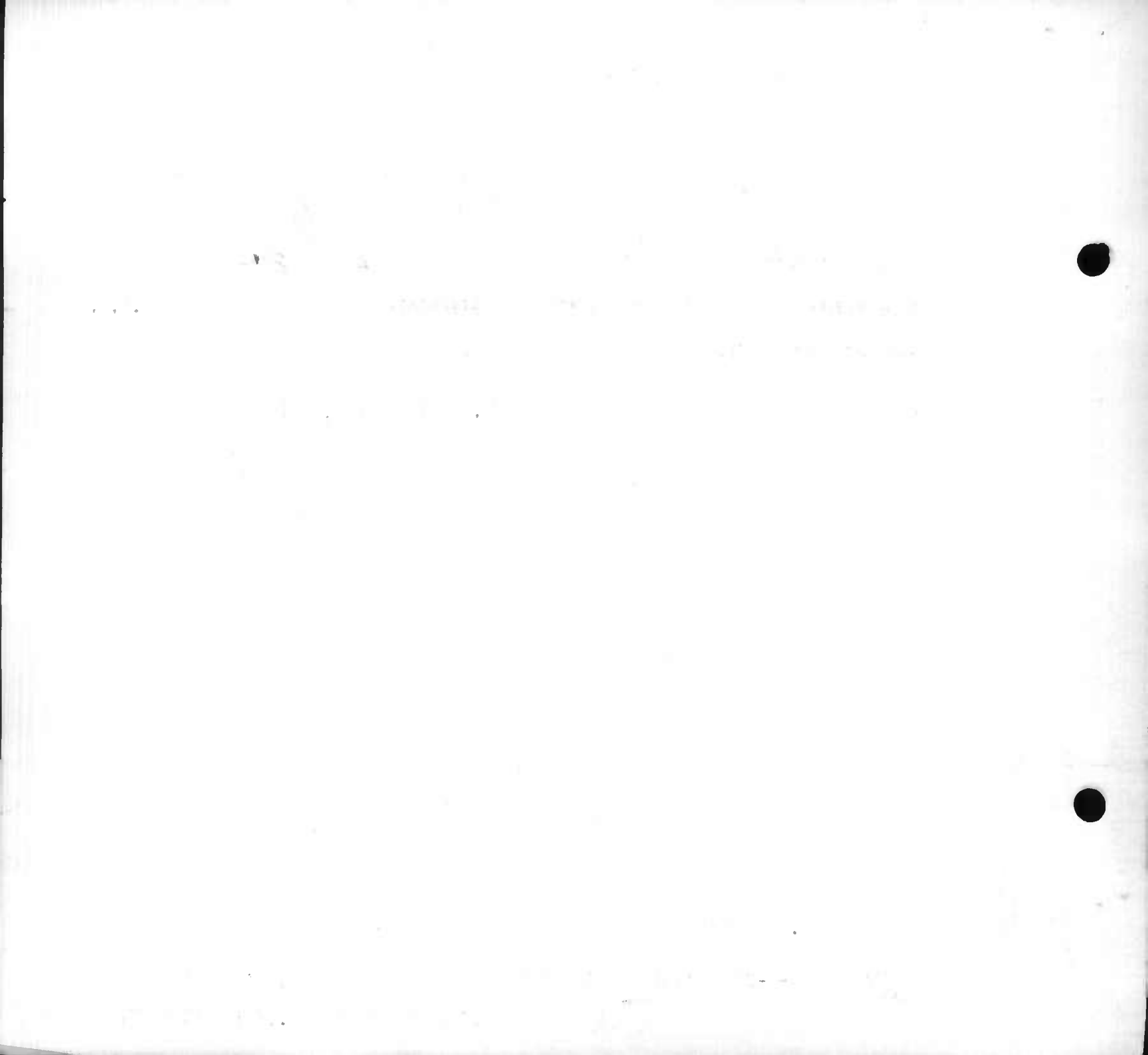
C. 514 70 3602		BIRTH NO.		70 3602	
1. NAME OF DECEASED (Type or Print) Clyde M. Campbell				2. DATE AND HOUR OF DEATH April 1, 1970 3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224				C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 424 S. Newkirk St. Baltimore, Md. 21224					
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-97	9. AGE (in years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Jesse Campbell				12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 191-07-3942	
17. INFORMANT 4940 Eastern Ave. BCH Records: Baltimore, Md. 21224				ADDRESS	
18. CAUSE OF DEATH					
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 6 min	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest					
(B) Post Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF:					
(C) Anterograde Cardiac disease					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 10-19 to 4-1 1970 that (H) (we) last saw the deceased alive on 4-1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. N. Brechtel M.D.				23B. DATE SIGNED 4-1-70	
23C. PHYSICIAN'S NAME (Type) J. N. Brechtel M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/5/1970		24C. NAME OF CEMETERY OR CREMATORY Lycippus Cemetery	
24D. LOCATION (City, town, or county) (State) West Moreland Co. Pennsylvania		25A. DATE REC'D BY HEALTH DEPT. APR 6 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Loring Byers 8728 Liberty Road 21133			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

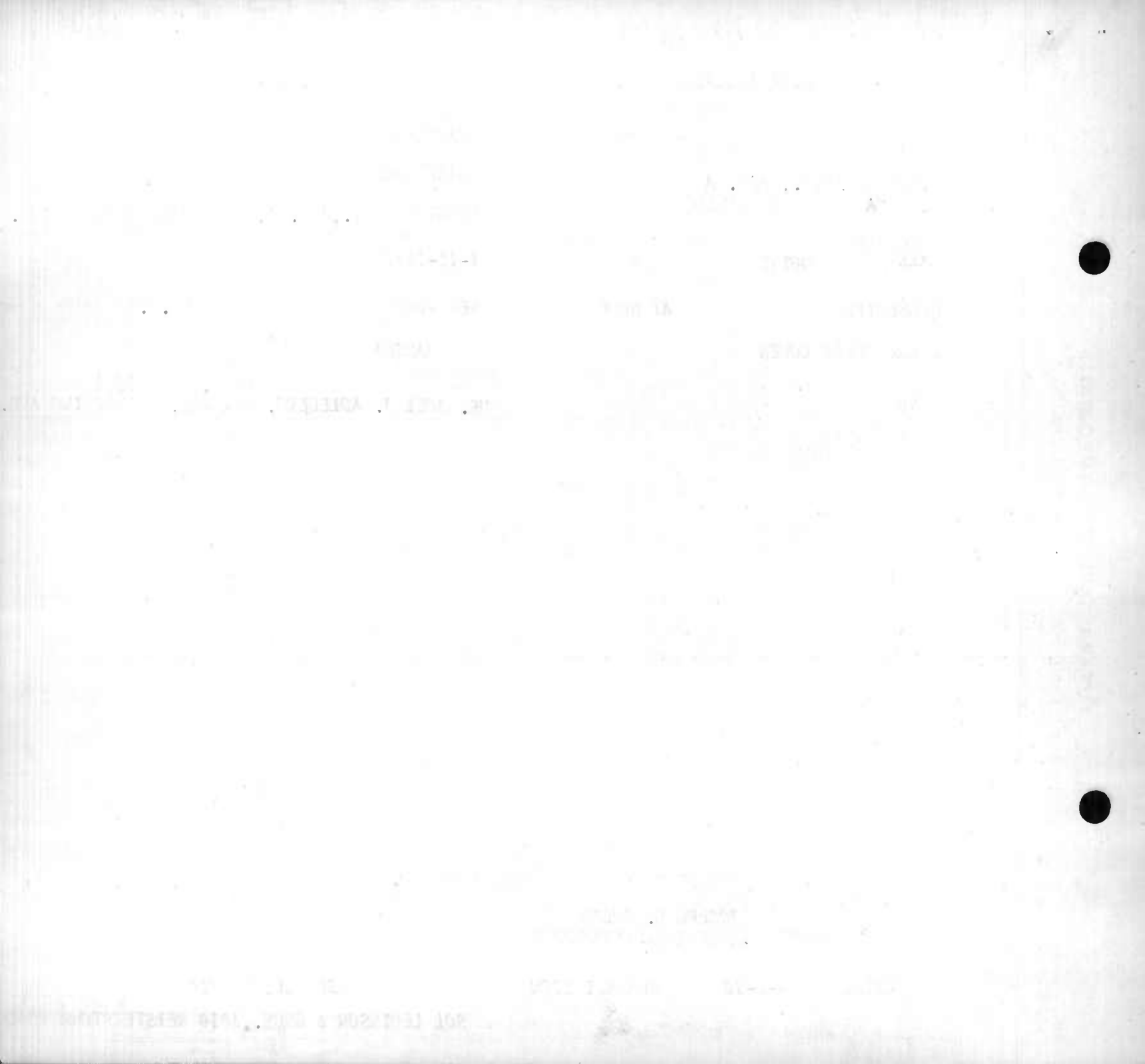
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3603</u>
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>ABRAHAM PLATT</u> <u>LOUIS</u>		2. DATE AND HOUR OF DEATH <u>3/31/70</u> <u>10:30 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP. Balto.</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2744</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>338 White Chapel</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/14/88</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROPRIETOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u>		9. AGE (In years last birthday) <u>81</u> 11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>
13. FATHER'S NAME <u>SCHMOEL JAKOW PLATT</u>		14. MOTHER'S MAIDEN NAME <u>SISA ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. MORTON PLATT, 6712 WESTBROOK ROAD</u>
18. CAUSE OF DEATH <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrhythmia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Myocardial Infarct.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>2/31/70</u> 19 to <u>3/31/70</u> 19 that (I) (we) lost saw the deceased alive on <u>3/31/70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>A. Mc Veny MD</u> 23C. PHYSICIAN'S NAME (Type) <u>A. MC VENY</u>				23B. DATE SIGNED <u>3/31/70</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-2-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u>
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1970</u>		
25B. NAME OF REGISTRAR <u>Sol Levinson</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

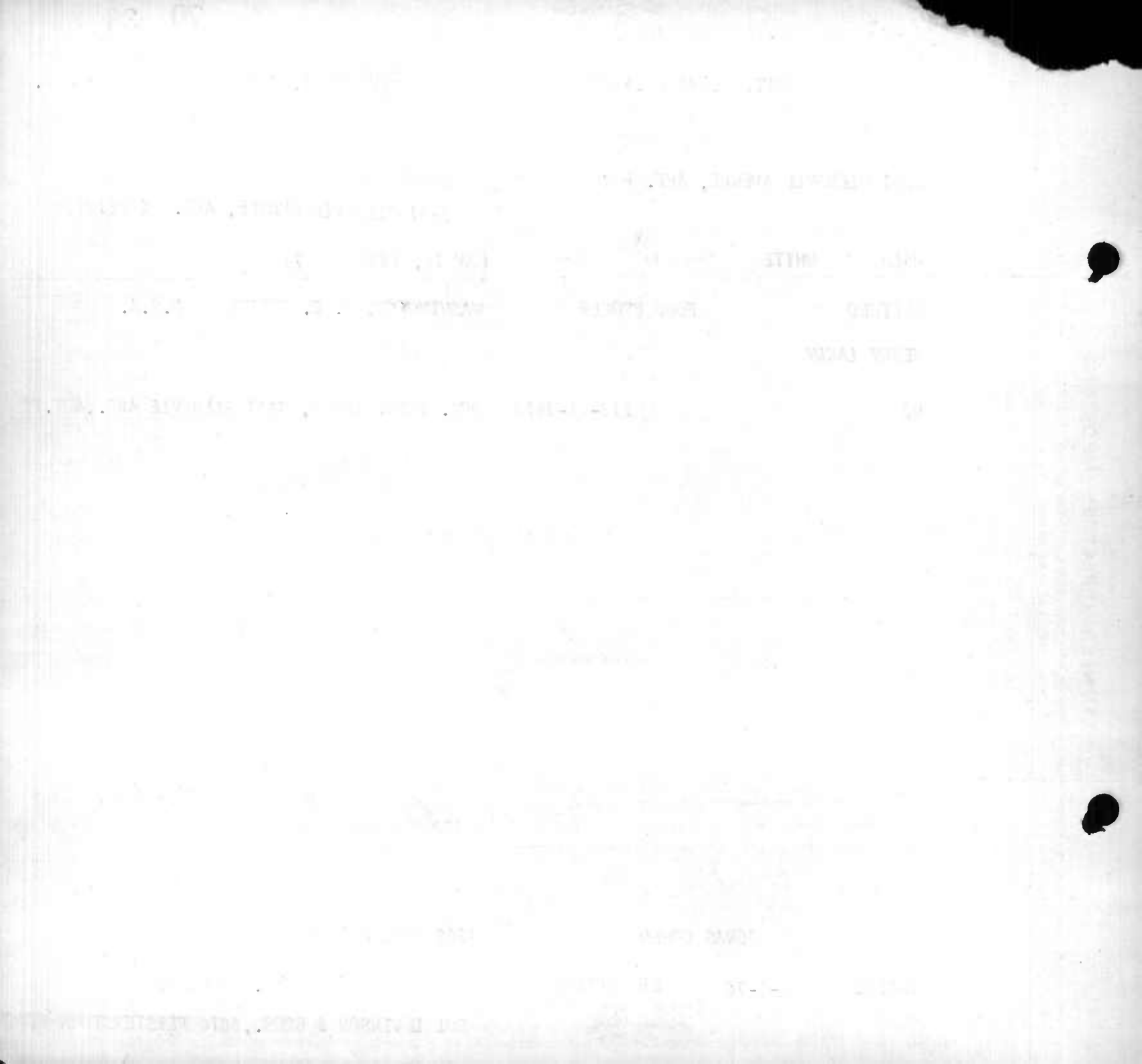
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3604
A-341 70 3604 CERTIFICATE OF DEATH		BIRTH NO. 1. NAME OF DECEASED (Type or Print) ETTA ADLEBERG		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) WILSHIRE APTS., APT. A 7236 PARK HEIGHTS AVENUE		2. DATE AND HOUR OF DEATH APRIL 1, 1970 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2720 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER WILSHIRE APTS., APT. A, 7236 PARK HEIGHTS AVE.		
5. SEX FEMALE XXXX	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1890 9. AGE (In years last birthday) 79 10. KIND OF BUSINESS OR INDUSTRY AT HOME 11. BIRTHPLACE (State or foreign country) NEW YORK 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		13. FATHER'S NAME ISAAC MEYER COHEN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 17. INFORMANT MR. JOEL J. ADLEBERG, Box 422, GREENSPRING AVE.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 151.9 I CAUSE OF DEATH Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Due to, or as a consequence of: Carcinoma of Stomach 8 months (B) Due to, or as a consequence of: (C) Due to, or as a consequence of:		
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from July 1970 to April 1970 , that (I) (we) last saw the deceased alive on April 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 23C. PHYSICIAN'S NAME (Type) JOSEPH B. GROSS		23B. DATE SIGNED April 1970 23D. ADDRESS 6911 Park Heights Ave Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-3-70 24C. NAME OF CEMETERY or CREMATORY SHAAREI ZION 24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

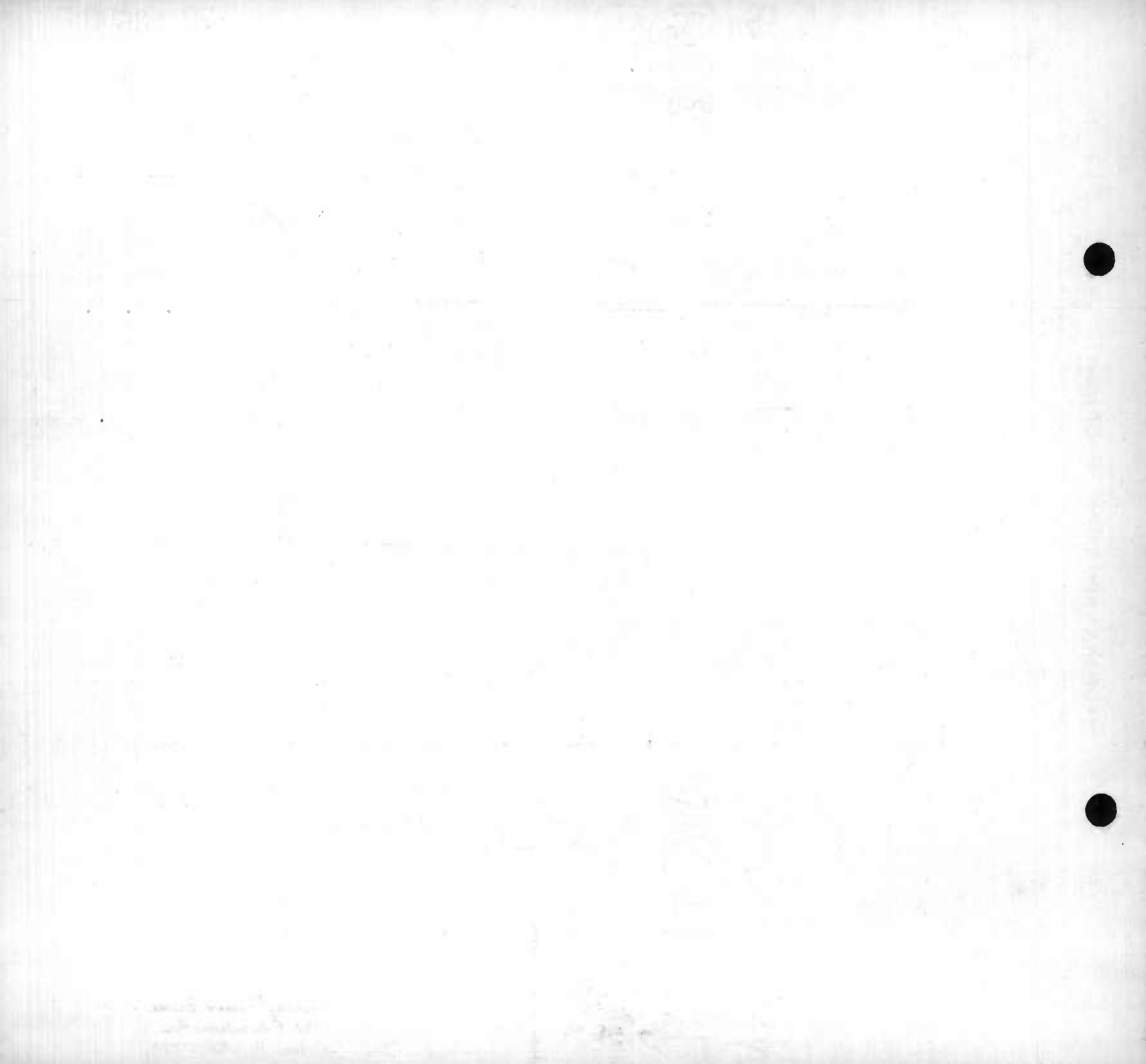
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3605	
1-530 70 3605				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DAVID BERNARD LANDY		MARCH 31, 1970 11:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 3651 GLENGYLE AVENUE, APT. F 2			A. STATE MARYLAND		
			B. COUNTY 2720		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3651 GLENGYLE AVENUE, APT. F2 #21215		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 10, 1890	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY FOOD BROKER	11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENRY LANDY			14. MOTHER'S MAIDEN NAME BETSY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-01-3910	17. INFORMANT MRS. IRENE LANDY, 3651 GLENGYLE AVE., APT. F2		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.3 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Pulmonary Edema due Arteriosclerotic heart disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) arteriosclerotic disease (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 20 yrs 25 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II bronchitis, acute				2 days	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 18 1970 to April 1 1969 , that (I) (we) last saw the deceased alive on Feb 18 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Jonas Cohen			23B. DATE SIGNED 4/1/70		
23C. PHYSICIAN'S NAME (Type) JONAS COHEN			23D. ADDRESS 6702 PARK HEIGHTS AVENUE		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-2-70	24C. NAME of CEMETERY or CREMATORY BETH TFILOH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3606
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Catherine E. Clark</i>		2. DATE AND HOUR OF DEATH <i>April 1, 1970 9:15 pm</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hospital</i> <i>Baltimore, Maryland</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>114 Melvin Ave.</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/27/90</i>	9. AGE (In years last birthday) <i>80</i> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-----</i>		
11. FATHER'S NAME <i>Rudolph Sommerwerck</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. MOTHER'S MAIDEN NAME <i>Mary Dimling</i>		14. INFORMANT <i>114 Melvin Ave - Catonsville</i> <i>Theodore L. Juene</i> <i>Same as above</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>		
17. CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>hypertension</i> (B) + Gangrene of foot & leg. DUE TO, OR AS A CONSEQUENCE OF: (C) -----				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>3/15</i> <i>1970</i> to <i>4/1</i> <i>1970</i> , that (I) (we) last saw the deceased alive on <i>9:15 pm 4/1 1970</i> and that in (my) (our) opinion death occurred on the date <i>4/1 1970</i> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>P. Bose</i>		23B. DATE SIGNED <i>4/1/70</i>		23C. PHYSICIAN'S NAME (Type) <i>PRATIMA BOSE M.D.</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/4/70</i>		24C. NAME of CEMETERY or CREMATORY <i>Lorraine Park Cemetery</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 6 1970</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR <i>Sterling Funeral Estate</i> ADDRESS <i>736 Edmondson Ave. Catonsville, Md. 21228</i>		



1

525 70 3607 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3607

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RICHARD JAHNIGEN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 1, 1970		M. 11
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year April 1, 1970		Hour 1:10 P. M.
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 12-23-1928		10. AGE (In years last birthday) 41		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Arthur Jahnigen		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Eng.
15. MOTHER'S MAIDEN NAME Uda Owens		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean		17. SOCIAL SECURITY NO. 218-22-9045
18. INFORMANT Mrs. Ruth V. Jahnigen, Same as # 4		19. CAUSE OF DEATH E 887 I		20. DATE OF OPERATION 2
21. AUTOPSY? (Yes or No) Yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Subject fell		23. DATE REC'D BY HEALTH DEPT. APR 6 1970
24. BURIAL CREMATION, REMOVAL (Specify) Burial		25. DATE REC'D BY HEALTH DEPT. APR 6 1970		26. NAME OF REGISTRAR Robert E. Taylor, M.D.
27. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		28. ADDRESS 1050 York Road Towson, Md. 21204		29. NAME OF REGISTRAR Robert E. Taylor, M.D.

VS 151-REV. 1/1/68

Letter from M.E.'s office

4-21-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3608	
G-450		70 3608		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Joseph A. Gallion		April 2, 1970		5 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
147 E. Randall St.		Maryland		2404	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER					
147 E. Randall St.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 26, 1886	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Capt.-Retired-B. F. D. Fire Dept.		Fire Dept.		Balto. Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U S A		Charles Gallion		Molly Richards	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		220 44 7036		Harold J. Gallion Union Chapel Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		B. DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		C. DUE TO, OR AS A CONSEQUENCE OF:			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 1 1965 to April 2 1970, that I last saw the deceased alive on April 1, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Vincent M. Messina M.D.				4/3/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Vincent M. Messina				1403 S. Charles St	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4 6 70		Cedar Hill	
24D. LOCATION (City, town, or county)		24E. STATE			
Brooklyn, A. A. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 8 1970		Robert E. Taylor M.D.		Mc Cully 130 E. Fort Ave	

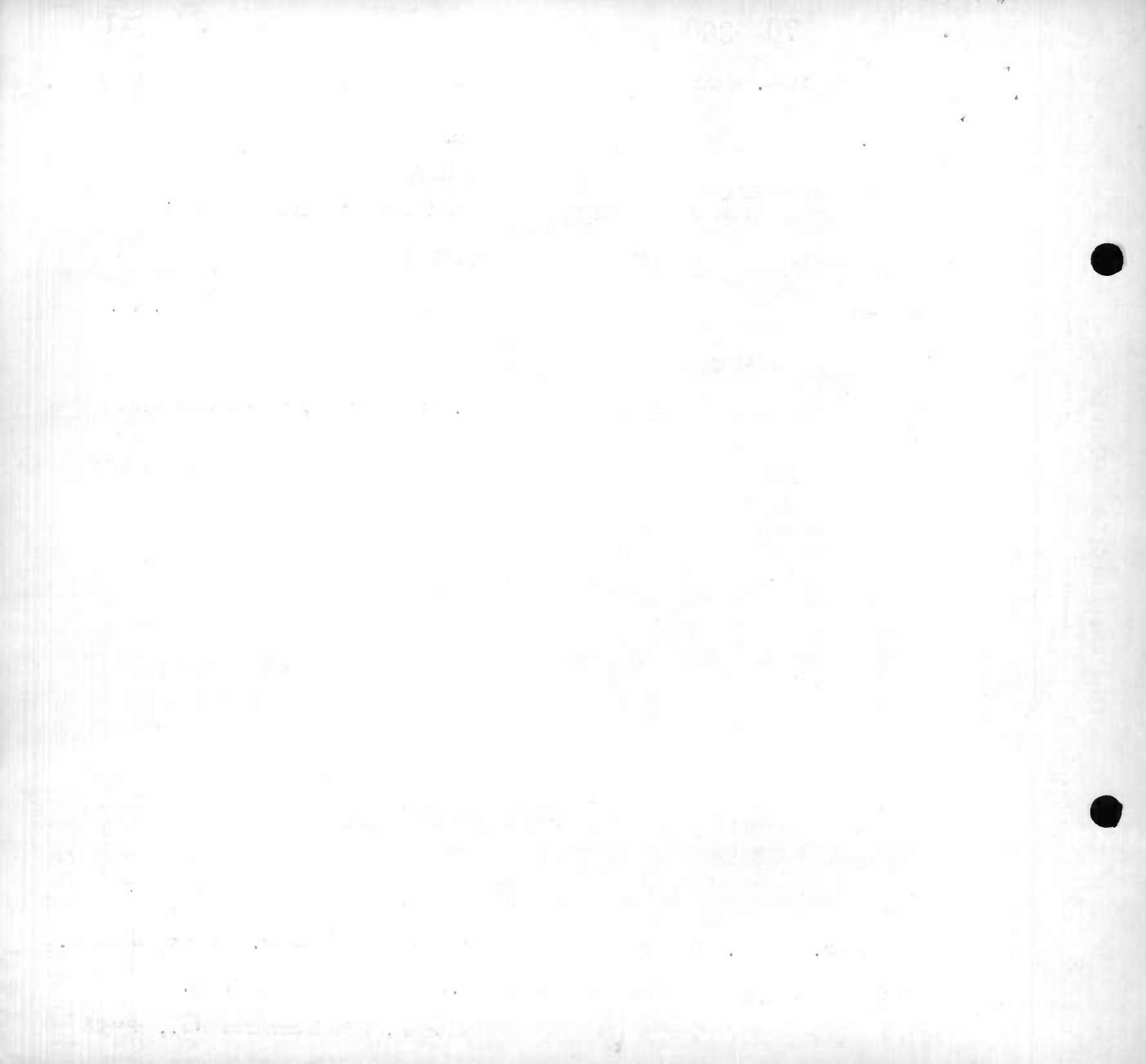
Handwritten text, possibly a title or heading, centered on the page.

Handwritten text at the bottom of the page, possibly a signature or date.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

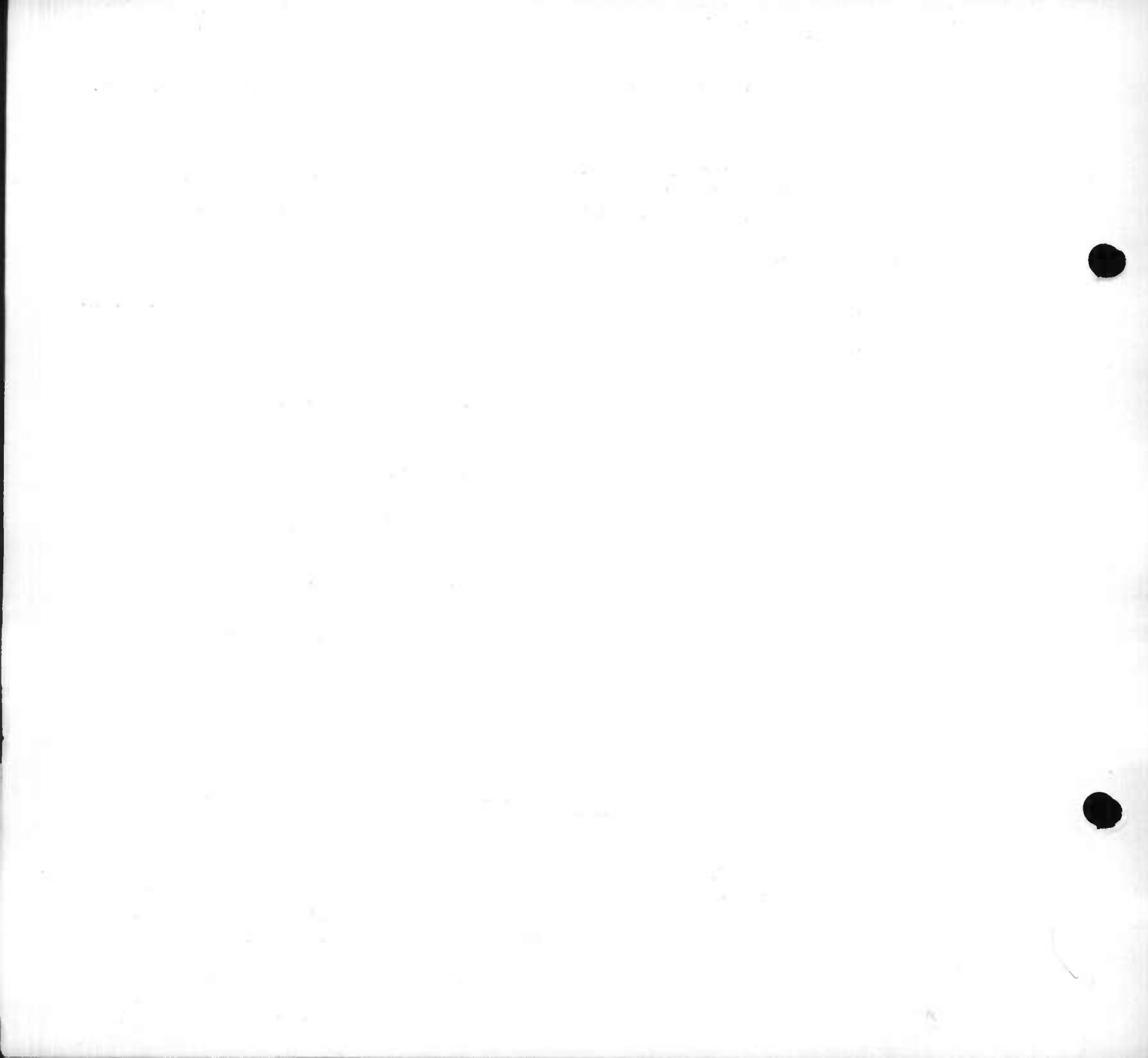
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3609	
<div style="display: flex; justify-content: space-between;"> K-400 70 3609 X </div>					
1. NAME OF DECEASED (Type or Print) Viola L. Kiehl			2. DATE AND HOUR OF DEATH 4/3/70 7:30a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Hood Nursing Home Edmondson at North Bend Road			A. STATE Fla B. COUNTY V-08		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Orlando		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1411 Virginia Drive (32803)		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/7/1897	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Eiting			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Edwin Eiting, 50 Hillvale Road		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 157.9 I CA OF PANCREAS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/24 19 78 to 4/2 19 70 , that (I) (we) last saw the deceased alive on 4/2 19 78 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul R. Ziegler				23B. DATE SIGNED 4/3/70	
23C. PHYSICIAN'S NAME (Type) Dr. Paul R. Ziegler				23D. ADDRESS 200 Chestnut Hill Dr. Ellicott City, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/4/70		24C. NAME of CEMETERY or CREMATORY Fernwood Cemetery Co.,	
24D. LOCATION (City, town, or county) (State) Philadelphia, Pa.		25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR John E. Witzke	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave.,		25D. ADDRESS 21228			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

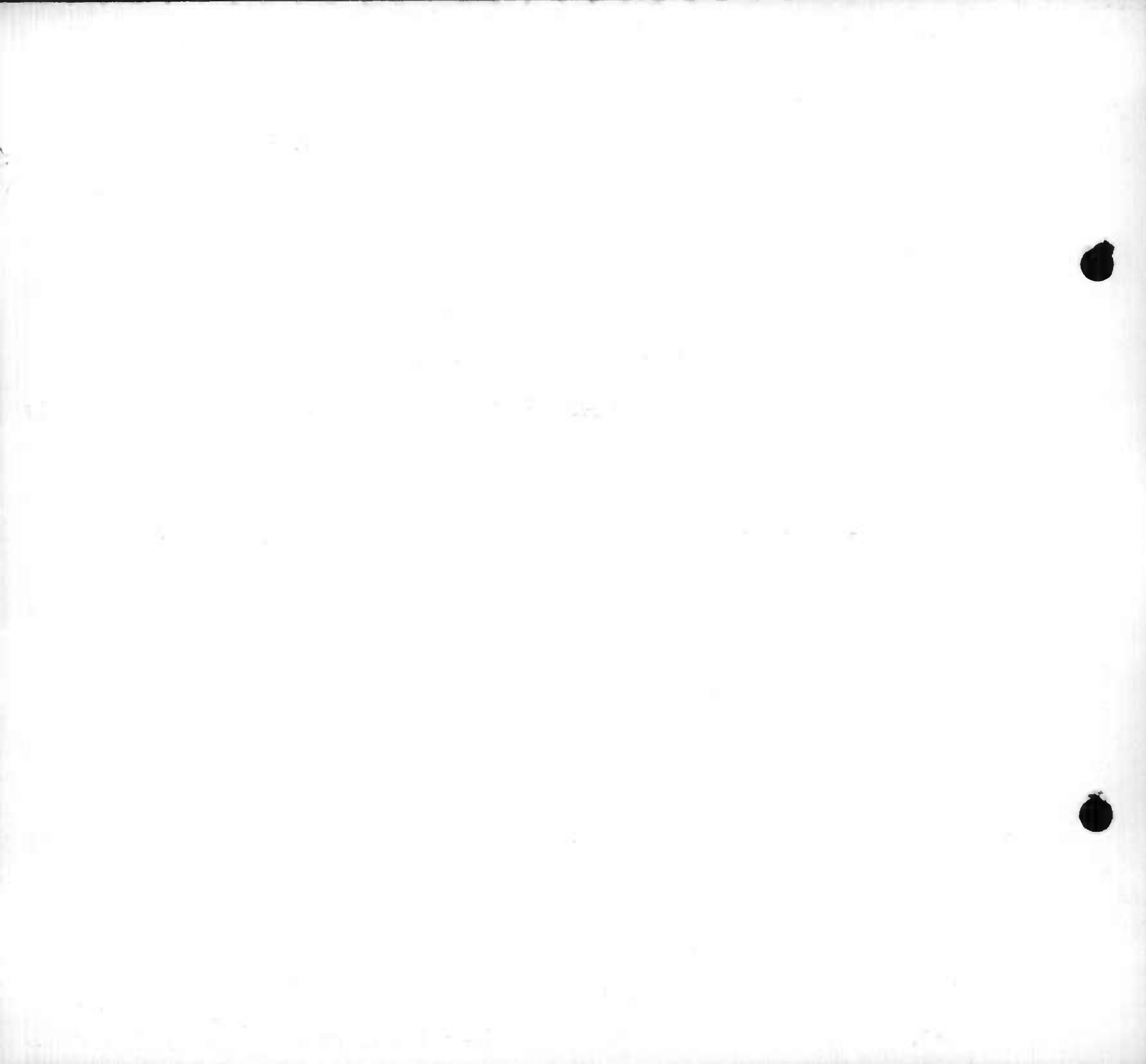
M-600 70 3610		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3610	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Moore, Zacharrah		April 2, 1970 1:15 p.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		A. STATE		B. COUNTY	
		Maryland		1402	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		516 McMechen Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
Male	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Unemployed				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
?		?		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mrs. Margaret Bowens - landlady - Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		?	
		Hepatic Coma			
		(B) DUE TO, OR AS A CONSEQUENCE OF:		?	
		Cirrhosis of the Liver			
		(C) DUE TO, OR AS A CONSEQUENCE OF:		?	
		Alcoholism			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Bleeding Esophageal Varices			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4-1-70 to 4-2-70 that (I) (we) last saw the deceased alive on 4-2-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
G. Tengco MD				4-2-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
G. Tengco MD				Provident Hospital, Inc. 1514 Division St. - Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4/6/70		MT Auburn Cemetry	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 6 1970		Robert E. Taylor, MD		Adolphus Halstead 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
H-655 70 3611				CERTIFICATE OF DEATH				X REG. NO. 70 3611			
1. NAME OF DECEASED (Type or Print) <u>SR. MARY SAMUELLE HARMAN</u>				2. DATE AND HOUR OF DEATH <u>3/30/70</u> <u>7:20 A.M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bon Secour Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u>				5. CITY OR TOWN <u>GLEN ARM.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Balt. & Pulaski St.</u>				E. STREET AND NUMBER <u>VILLA MARIA.</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/32</u>		9. AGE (in years last birthday) <u>37</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NUN</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>SAMUEL F. HARMAN.</u>				14. MOTHER'S MAIDEN NAME <u>BARNES. Helena</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>15-27-9185</u>				17. INFORMANT <u>Convent Records</u>			
ADDRESS <u>6401 N. Charles St.</u>											
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CA of Pancreas & Metastasis.</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/3</u> 19 <u>70</u> to <u>3/30</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/28</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Mayuree Khongcharoensuk, M.D.</u>								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/30/70.</u>	
23C. PHYSICIAN'S NAME (Type) <u>MAYUREE KHONGCHAROENSUK M.D.</u>								23D. ADDRESS <u>Bon Secours Hosp. Balto., Md. 21223.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>3-2-70</u>				24C. NAME of CEMETERY or CREMATORY <u>SISTERS CEMETERY</u>			
24D. LOCATION (City, town, or county) (State) <u>GLEN ARM, BALT. CT. MD.</u>											
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>				25C. FUNERAL DIRECTOR <u>RAYMOND J. CORRAN</u>			
ADDRESS <u>817 SCARLETT DR TOWSON, MD. 21204</u>											



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

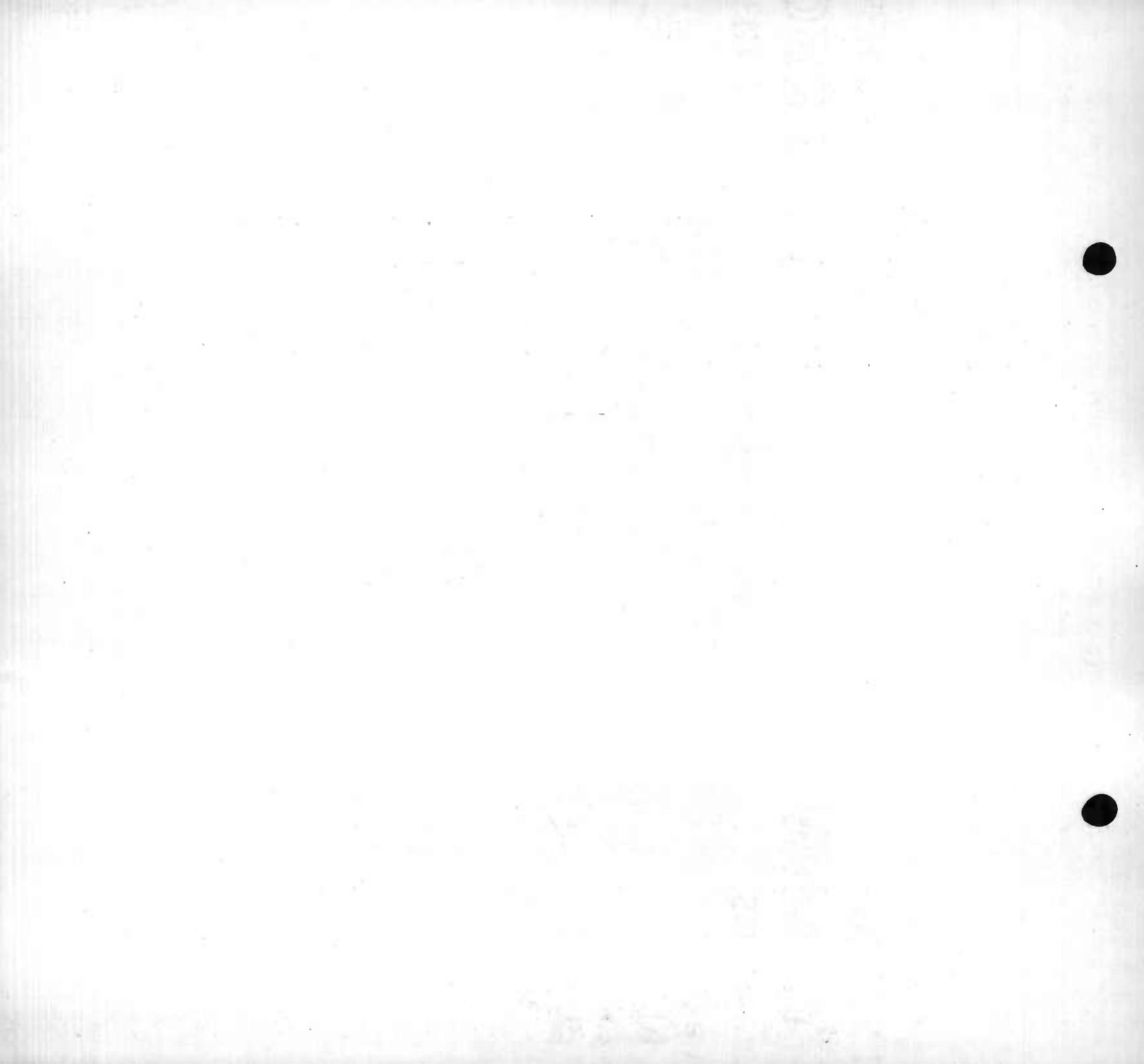
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 3612</u>	
<u>W-463 70 3612</u> BIRTH NO. <u>70-05743</u>				2. DATE AND HOUR OF DEATH <u>4/2/70</u> <u>5 25</u> A.M.			
1. NAME OF DECEASED (Type or Print) <u>BABY BOY WILLARD</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>ANNE ARUNDEL</u> C. CITY OR TOWN <u>GLEN BURNIE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>501 B & A BLVD</u>			
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-70</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>-----</u>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>WILLIAM WILLARD</u>				14. MOTHER'S MAIDEN NAME <u>NANCY DEWS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <u>776.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>cardiorespiratory arrest</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>hyaline membrane disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF:				<u>36 hours</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>possible congenital heart disease</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (at) (this hospital) attended the deceased, from <u>3/31</u> 19 <u>70</u> to <u>4/2</u> 19 <u>70</u> that (I) (was) last saw the deceased alive on <u>4/2</u> 19 <u>70</u> and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (was) <u>(did)</u> view the body after death.							
23A. SIGNATURE <u>James W. Hanson MD</u>				23B. DATE SIGNED <u>4/2/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>JAMES WM. HANSON MD</u>				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>4/2/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Johns Hopkins Hospital</u>		24D. LOCATION (City, town, or county) (State) <u>601 N Broadway Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>HOSPITAL DISPOSAL</u>	
				ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3613
BIRTH NO. 70 3613		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Hilda Cathcart		2. DATE AND HOUR OF DEATH 4-1-70 1:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Center		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1601 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 827 N. Arlington Avenue		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1889	9. AGE (In years last birthday) 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Turner		
14. MOTHER'S MAIDEN NAME Ells Greenland		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 109-07-1022		17. INFORMANT ADDRESS Antoinette Hill-7124 Minnie Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.21 (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thromb (B) Hypertension C V disease (C) arteriosclerosis generalized		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mth years years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3/18 19 70 to 4/1 19 70 , that (I) (we) last saw the deceased alive on 4/11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Alan H. Macht MD		23B. DATE SIGNED 4/1/70		23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT MD
23D. ADDRESS 2 E Real St		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 4/4/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Shesport, Md.
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR P. E. E. Taylor, MD		25C. FUNERAL DIRECTOR ADDRESS Milton Clickon 1129 N. Calvermont



H-620

70 3614

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3614

BIRTH NO.

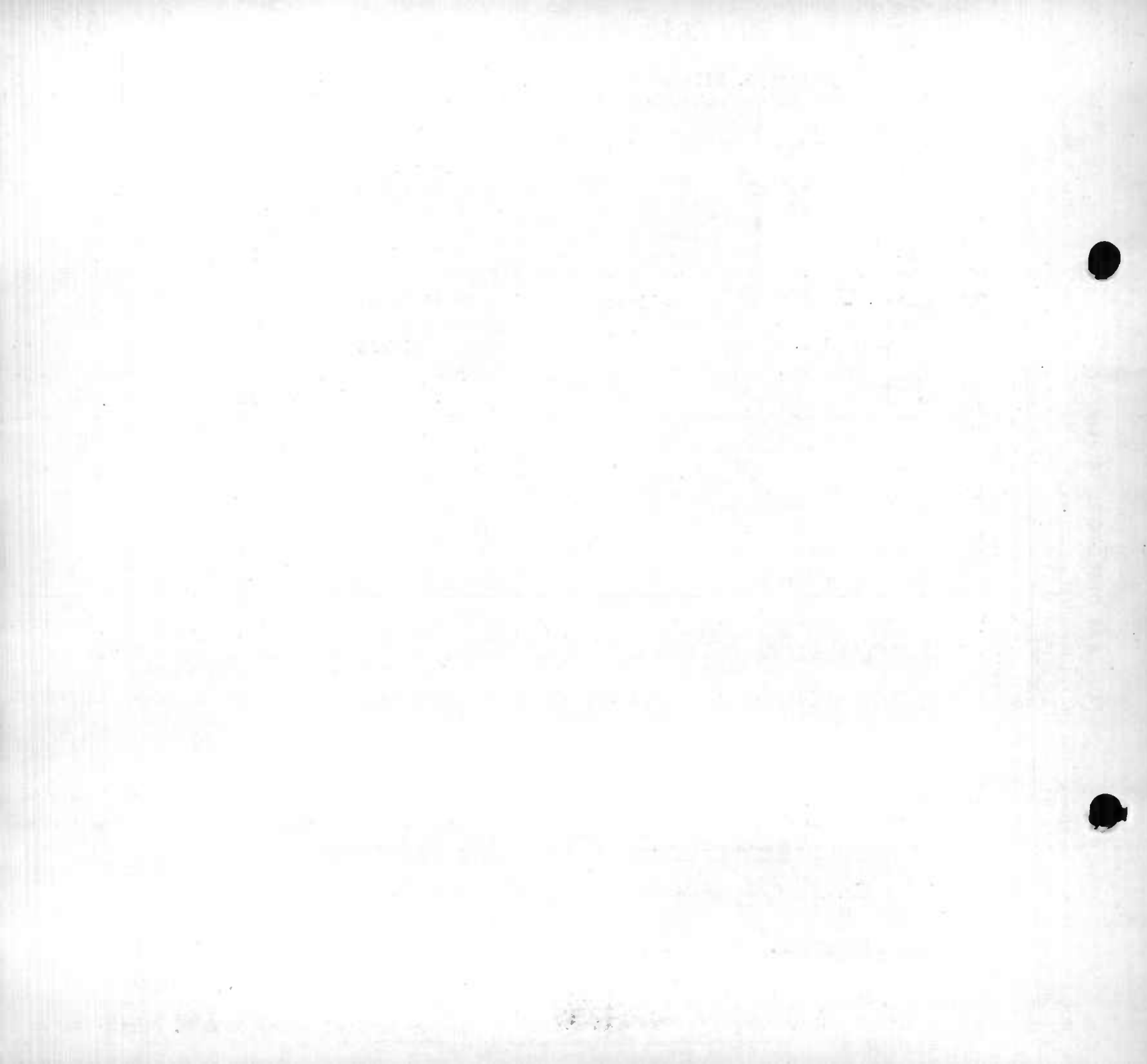
REG. NO.

1. NAME OF DECEASED (Type or Print) HATTIE HARRIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> April 1, 1970		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD April 1, 1970		9:28 P.M.	
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH March 25, 1917		10. AGE (In years, last birthday) 53		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME John Sellers		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Alaslee		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Patricia McCay		19. ADDRESS 2009 Hillman St.		20. DATE OF OPERATION	
21. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Springate		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 2, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/6/70		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Milton Ellickson	
26A. ADDRESS 11297 Caroline		26B. ADDRESS 11297 Caroline		26C. ADDRESS 11297 Caroline	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3615	
BIRTH NO.		70 3615		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Elliott J. Wilson			2. DATE AND HOUR OF DEATH 4/1/70		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1547		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2906 Windsor Avenue		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/88	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter - B & O		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Fred Wilson		
14. MOTHER'S MAIDEN NAME Clariss ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Laura Wilson 2906 Windsor Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 412.414-250.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			CAUSE OF DEATH ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART D. (C) DIABETES MELLITUS 1 year		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7-7-1969 to 4-1-1970 , that (1) (we) last saw the deceased alive on 3-31-1970 and that I (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard F. Tyson, M.D.			23B. DATE SIGNED 4-3-70		23C. ADDRESS 936 W. North Ave. Balt. Md. 21217
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/6/70		
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park			24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland		
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		
25C. FUNERAL DIRECTOR Nutter Funeral Home			25D. ADDRESS 3035 W. North Avenue		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>70 3616</u>	
W-452 <u>70 3616</u>		BIRTH NO. <u>70-0475</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Williams</u>			2. DATE AND HOUR OF DEATH <u>3-26-70</u> <u>9:15</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2802</u>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4205 Liberty Heights Ave.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-70</u>	9. AGE (in years last birthday) <u>9</u> <u>3</u> <u>25</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henry Williams</u>		14. MOTHER'S MAIDEN NAME <u>Juanita Muse</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>777X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
MEDICAL CERTIFICATION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-17-70</u> 19 to <u>3-26-70</u> 19 that (I) (we) last saw the deceased alive on <u>3-26-70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L. Estella</u>			23B. DATE SIGNED <u>March 27, 1970</u>		
23C. PHYSICIAN'S NAME (Type) <u>L. Estella</u>			23D. ADDRESS <u>M. D.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-2-70</u>		24C. NAME of CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

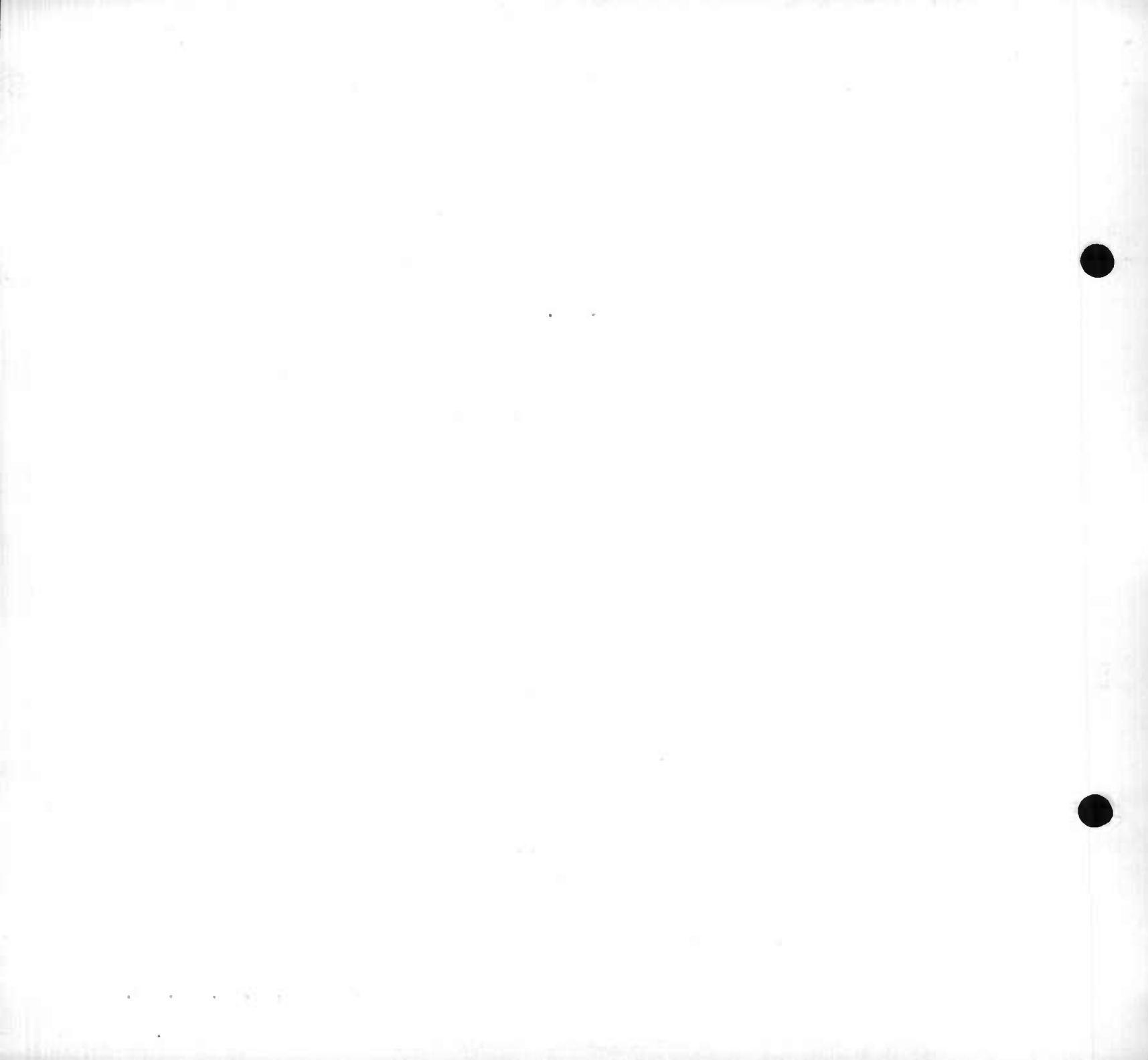
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-450 70 3617		BALTIMORE CITY HEALTH DEPARTMENT		28 470 23 RS REG. NO. 3617	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES ALLEN		2. DATE AND HOUR OF DEATH 15 MARCH 1970 9:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 603		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 210 N. Montford Avenue 21224	
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/24	9. AGE (in years last birthday) 45	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 303.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (B) INANITION DUE TO, OR AS A CONSEQUENCE OF: (C) CHRONIC ALCOHOLISM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 DAYS 1 YEAR 30 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		GASTROINTESTINAL BLEED		2 WEEKS	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (M) (this hospital) attended the deceased from 3/3 19 70 to 3/15 19 70 that (M) (we) last saw the deceased alive on 3/15 19 70 and that (M) (our) opinion death occurred on the date and hour and from the causes stated above. (M) (We) (did) (did not) view the body after death.		23A. SIGNATURE Karl Kramer DEGREE	
23B. DATE SIGNED 3/15/70		23C. PHYSICIAN'S NAME (Type) Karl Kramer, M.D. DEGREE		23D. ADDRESS ANATOMY BOARD OF MARYLAND Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) 4-6-70		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City or ward or lot) (State)		25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		25D. ADDRESS		25E. ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

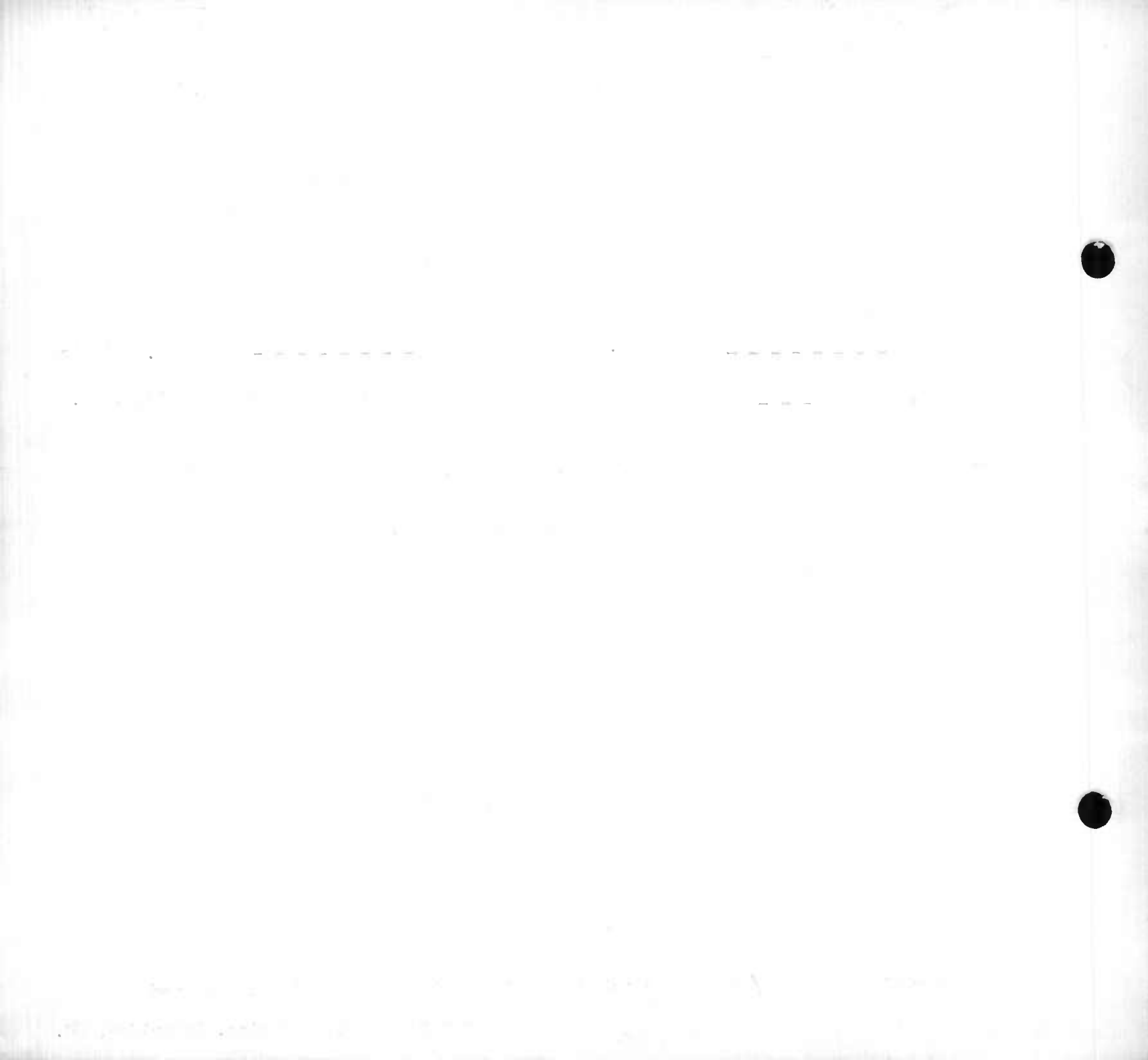
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3618	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) MR EDWARD A. CLUNEY		2. DATE AND HOUR OF DEATH 4 / 3 / 70 9.30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2006 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1 North Hilton Street			
5. SEX MALE 6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 04/18/99 9. AGE (in years last birthday) 70 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Reader 10B. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.	
11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Cluney, Robert J. 14. MOTHER'S MAIDEN NAME Hayes, Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212 052836		17. INFORMANT Admission Sheet ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-weight: bold;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Carcinoma esophagus 3-4 weeks and cardia of stomach.	
19A. DATE OF OPERATION 3/31/70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Stomach & Esophagus		20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3/14/1970 to 4/3/1970 that (I) (we) last saw the deceased alive on 4/3/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE V. Vongvattanyu M.D.		23B. DATE SIGNED 4/3/70		23C. PHYSICIAN'S NAME (Typo) V. VONGVATONYU MD	
23D. ADDRESS Bon Secours Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4 7 70 24C. NAME of CEMETERY or CREMATORY Holy Cross			
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 8 1970 25B. NAME OF REGISTRAR R. E. J. B. M. D. 25C. FUNERAL DIRECTOR Mc Gully ADDRESS 130 E. Fort Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3619	
BIRTH NO. 70 3619				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>DUKES HERMAN R.</u>			2. DATE AND HOUR OF DEATH <u>5:25AM 4/2/70</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTH. BALT: GENERAL Hosp</u>			A. STATE <u>MARYLAND</u>		B. COUNTY <u>2404</u>
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>1829 Light Street BALT MD 21203</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-1-01</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>F-(-Dec-) Frank E. Dukes</u>			14. MOTHER'S MAIDEN NAME <u>F-(-Dec-) Mary L. Phillips</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>LeCompte Funeral Service, Cambridge, Md.</u>		
18. <u>441.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>DISSECTING ANEURISM</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>MONTHS</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/31/70</u> 19 to <u>4/2/70</u> 19 that (I) (we) last saw the deceased alive on <u>5:25AM 4/2 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Hanbir S. Saluja</u>				23B. DATE SIGNED <u>4/2/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>DHANBIR S. SALUJA MD</u>		23D. ADDRESS <u>S.B.G. Hospital 3001 S HANOVER Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/4/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>	
24D. LOCATION (City, town, or county) <u>Cambridge, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1970</u>		25B. NAME OF REGISTRAR <u>Phyllis E. Taylor MD</u>		25C. FUNERAL DIRECTOR ADDRESS <u>LeCompte Funeral Service, Cambridge, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 3620	
B-412 70 3620				1. NAME OF DECEASED (Type or Print) DALE BLUBAUGH		2. DATE AND HOUR OF DEATH 4/1/70 1:15	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL 33				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ALLEGANY C. CITY OR TOWN MIDLAND D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER NONE			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-60		9. AGE (In years last birthday) 9	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL BOY		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAYMOND BLUBAUGH				14. MOTHER'S MAIDEN NAME ERMA GALLAGHER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N.A.		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. RAYMOND T. BLUBAUGH, MIDLAND, MD.			
18. 289.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.) CARDIO RESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. UREMIA; RENAL FAILURE MARROW FAILURE Poly ARTERITIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None			
21D. TIME OF INJURY (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from January 1970 to present , that (I) (we) lost saw the deceased alive on 4/1/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.							
23A. SIGNATURE David Valle				23B. DATE SIGNED 4/1/70		23C. PHYSICIAN'S NAME (Type) DAVID VALLE	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL				23E. FUNERAL DIRECTOR MARIELOU M. SOWERS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/4/70		24C. NAME OF CEMETERY or CREMATORY FROSTBURG MEM. PARK		24D. LOCATION (City, town, or county) (State) FROSTBURG, ALLEGANY, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Paul E. Taylor		25C. FUNERAL HOME HAER-SOWERS FUNERAL HOME, 60 W. MAIN FROSTBURG			

1870-1871

1872-1873

1874-1875

1876-1877

1878-1879

1880-1881

1882-1883

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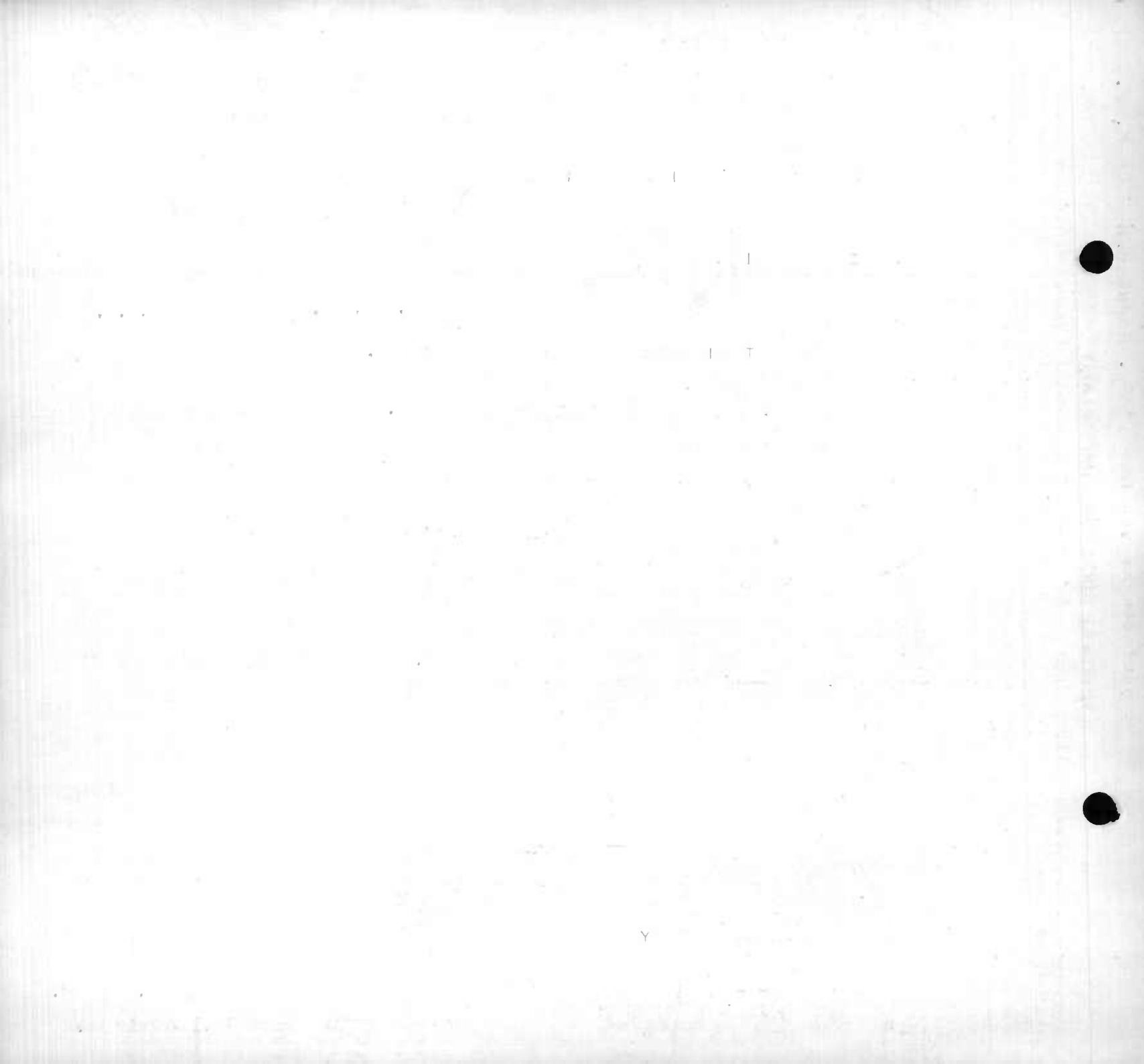
1890

1891-1892

FUNERAL DIRECTOR: IMPORTANT

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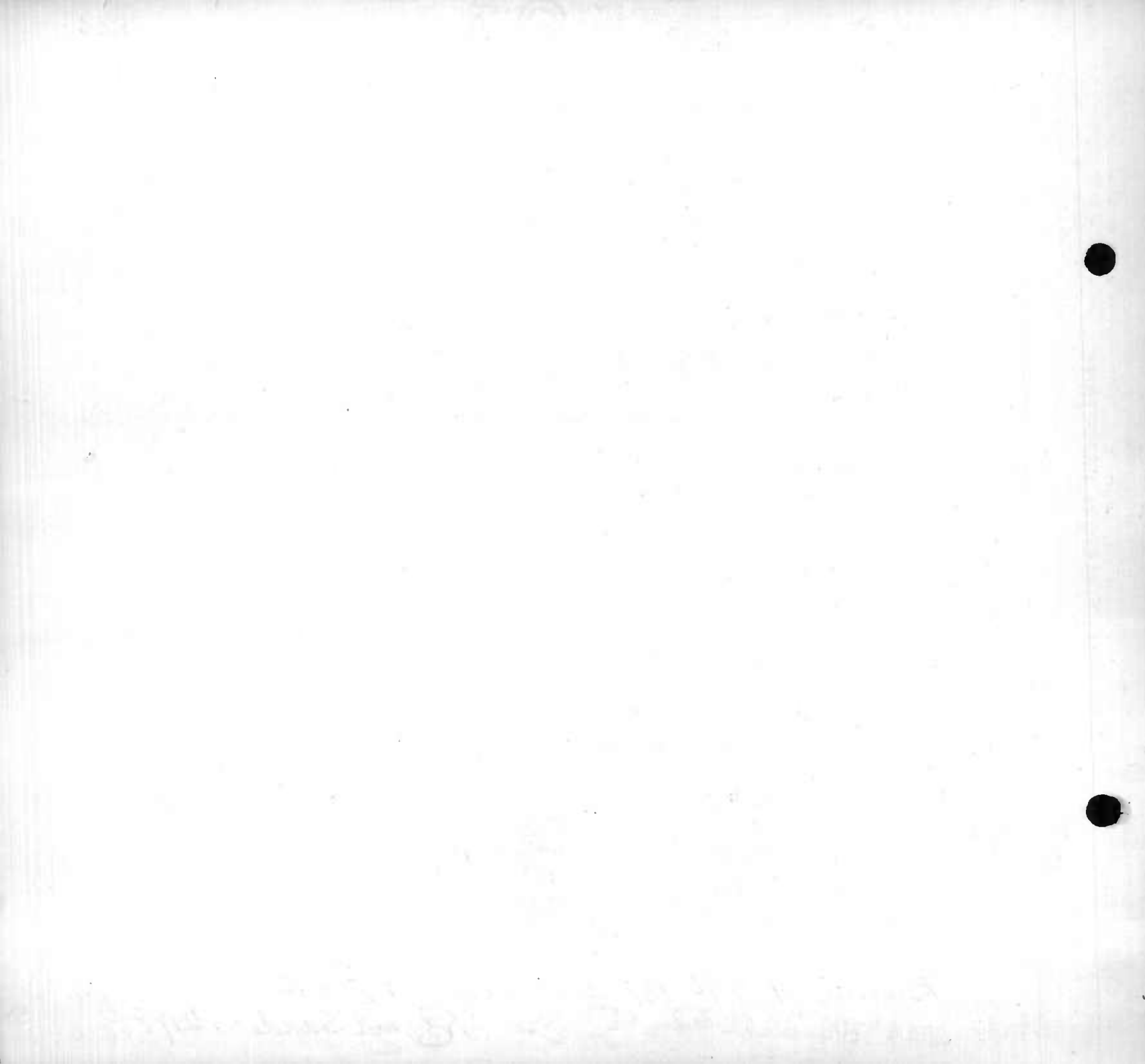
K-200 70 3621		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3621	
BIRTH NO.		1. NAME OF DECEASED (Type of Print) KEYS, MARGARET		2. DATE AND HOUR OF DEATH 3-31-70 9:40 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balto. 5300			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN WHITE MARSH		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5 AFFELD AVE. 21162			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-20	9. AGE (In years lost birth day) 49	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10B. KIND OF BUSINESS OR INDUSTRY Board of Education		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ERNEST SIMMONS		14. MOTHER'S MAIDEN NAME EVA T. TREMPER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-20-4951		17. INFORMANT Lewis W. Keys 5 Affeld Avenue White Marsh	
18. 441.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION (B) HEMORRHAGIC SHOCK (C) RESECTION THORACIC ANEURYSM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		DISSECTING ANEURYSM			
19A. DATE OF OPERATION 3/31/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DISSECTING AORTIC ANEURYSM		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/31/70 4PM 19 to 3/31/70 9:41PM, that (I) (we) last saw the deceased alive on 3/31/70 9:41PM, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Arthur Jenny MD		23B. DATE SIGNED 3/31/70		23C. PHYSICIAN'S NAME (Type) ARTHUR JENNY	
23D. ADDRESS Johns Hopkins Hospital		23E. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-4-1970		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION Parkville Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. APR 6 1970		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3622	
B-650 70 3622 BIRTH NO. 1. NAME OF DECEASED (Type or Print) BROWN WILLIAM E.		CERTIFICATE OF DEATH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital 46430 Ashburton Street Baltimore.		2. DATE AND HOUR OF DEATH APRIL 1st 1970 12:09 a.m. 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MD. 21229, B. COUNTY 2037 C. CITY OR TOWN Baltimore. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 516 N. Dennison St.			
5. SEX M.	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3.20.1910.	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed since 1951		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John A. Ovey		14. MOTHER'S MAIDEN NAME Leola Ovey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Violet E. Brown 516 Dennison St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebro Vascular Accident DUE TO, OR AS A CONSEQUENCE OF: (L) (B) - DUE TO, OR AS A CONSEQUENCE OF: (C) -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3.28.70 4.1.70.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 28th March 1970 to 1st April 1970, that (I) (we) lost saw the deceased alive on 21st March 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. G. Nanes M.D.				23B. DATE SIGNED 1st April 70.	
23C. PHYSICIAN'S NAME (Type) P. G. Nanes M.D.				23D. ADDRESS Lutheran Hospital Ashburton St. Baltimore.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-4-70		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem Balto	
24D. LOCATION (City, town, or county) MD		25A. DATE REC'D BY HEALTH DEPT. APR 6 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Rayner Sanders 217 E Preston St			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3623	
M-430 70 3623				CERTIFICATE OF DEATH	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)	
				RUTH MULLEN	
2. DATE AND HOUR OF DEATH				April 1, 1970 1:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
JOHNS HOPKINS HOSP				MARYLAND BALTIMORE CITY 1204	
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
FEMALE NEGRO				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH 9. AGE (In years lost birthday) 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY				E. STREET AND NUMBER	
6-3-29 40				1917 GUILFORD AVENUE	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Baltimore					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
LAWRENCE GREEN				MARGARET TWOGOOD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
				17. INFORMANT ADDRESS	
				Hospital Record	
18. 303.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gram-negative pneumonia + sepsis 48 hours	
				(B) Chronic ethanolism	
				(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from March 30 19 70 to April 1 19 70, that (I) (we) last saw the deceased alive on April 1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Leroy M Parker M.D. DEGREE				April 1, 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
LEROY M PARKER DEGREE				JOHNS HOPKINS HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-4-70		Arbutus Memorial Park Balto Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 6 1970		Robert E. Parker JR		Rayner Sanders 217 E. Preston ST	

N-165

70 3624

BALTIMORE CITY HEALTH DEPARTMENT

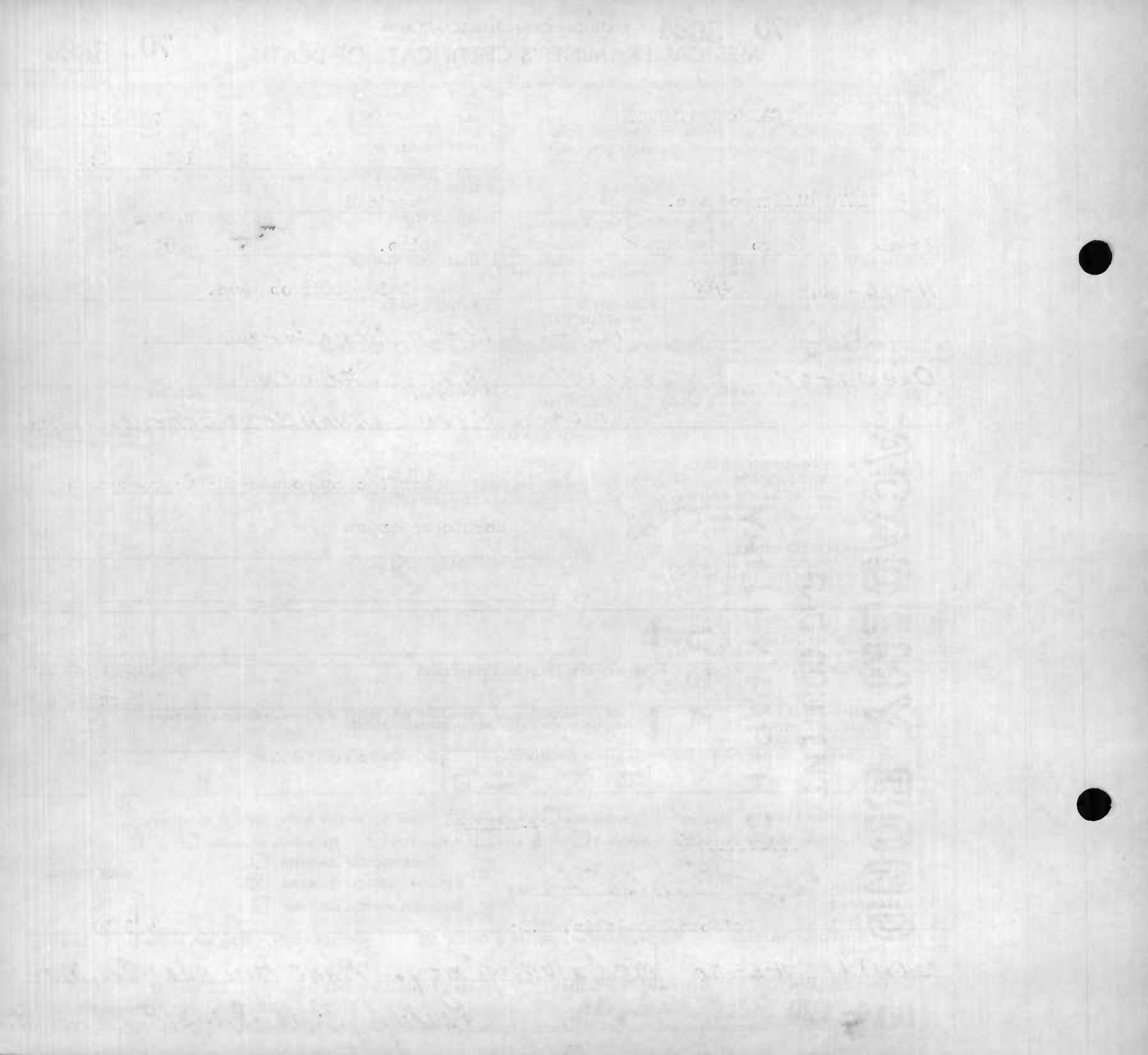
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3624

BIRTH NO.

REG. NO.

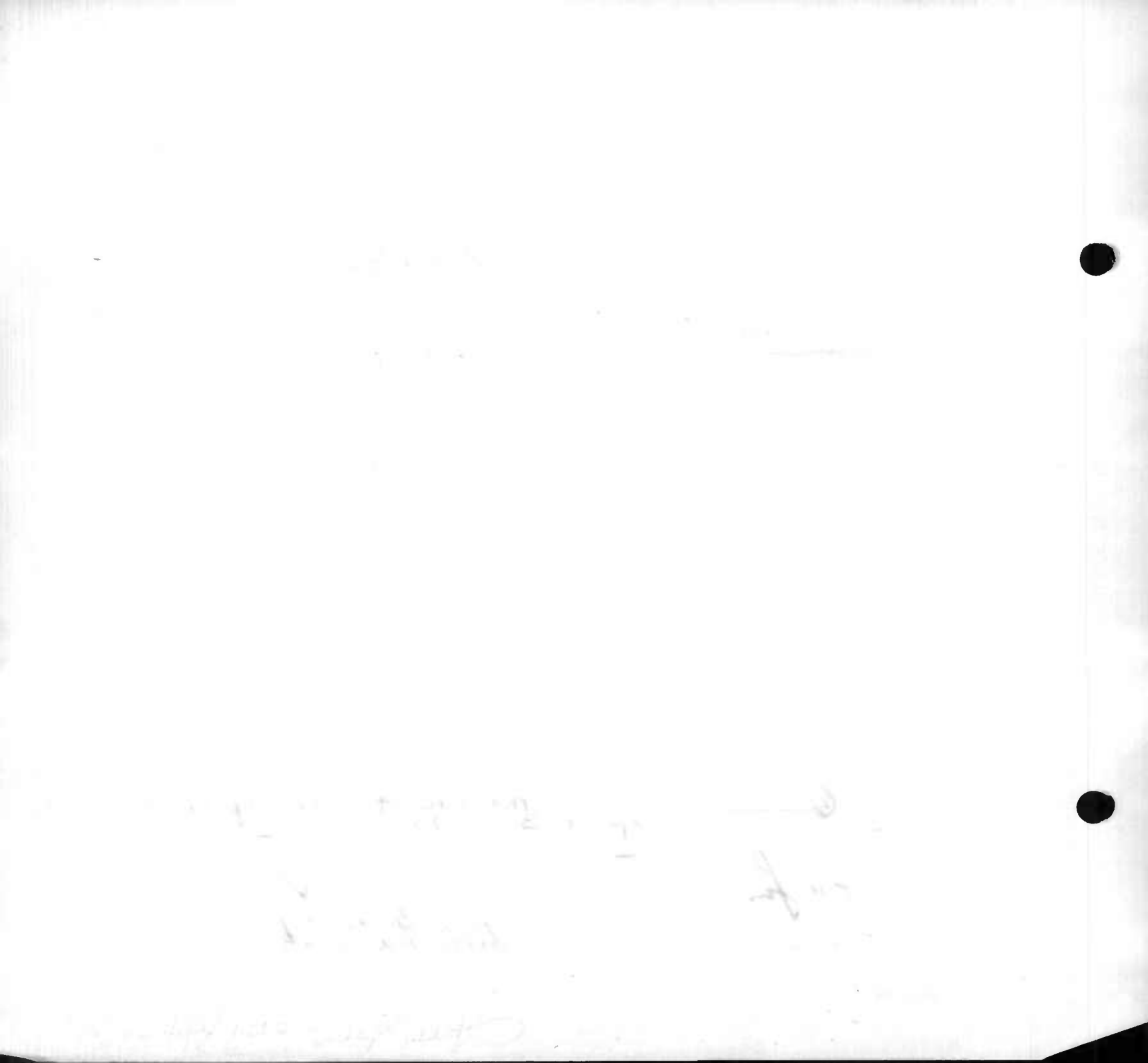
1. NAME OF DECEASED (Type or Print) GAYNELL NEWBORN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 2 70 1:10 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2130 Cliftwood Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour April 2, 1970 1:10 p M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 802			
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 11-16-21	10. AGE (In years lost birthday) 48	E. STREET AND NUMBER 2130 Cliftwood Ave.	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.B.	
13. FATHER'S NAME Peter Roundtree		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator	
15. MOTHER'S MAIDEN NAME Mary Cannon		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 217-26-7826		18. INFORMANT ADDRESS Mary Cannon 3038 E. Federal St.	
19. 441.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac tamponade due to rupture of aortic aneurysm		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Partial YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-5-70	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cnty.		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Randolph Pollick		25D. ADDRESS 2431 E. Oliver St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

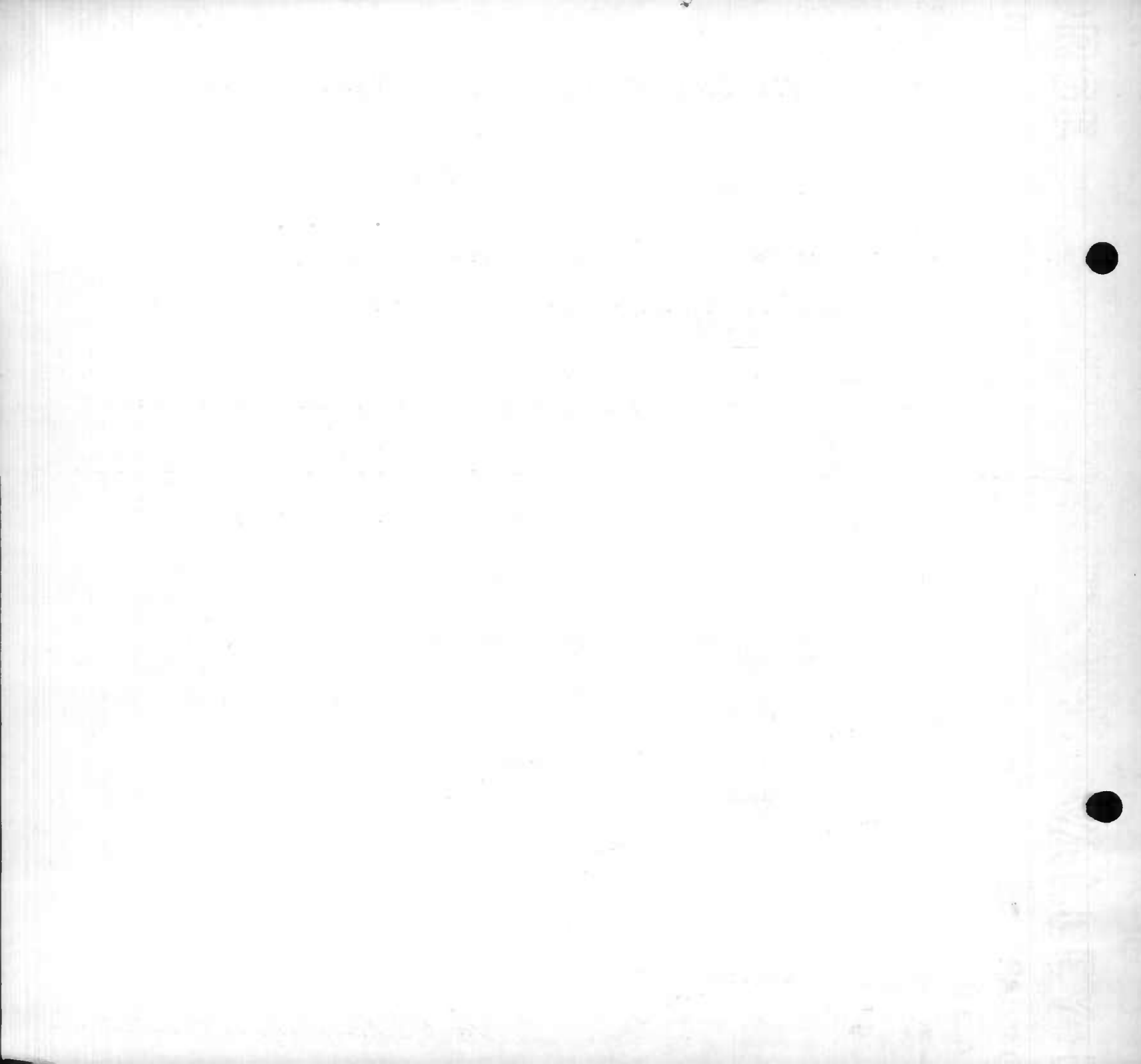
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3625</u>	
BIRTH NO. <u>70 3625</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>JOHN J. GOODWIN</u>		2. DATE AND HOUR OF DEATH <u>APRIL 3, 1970</u> <u>2:45</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME AND HOSPITAL</u> <u>35</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3141 ELLIOTT STREET</u>		<u>21224</u>			
5. SEX <u>M</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 5, 1898</u>	9. AGE (in years last birthday) <u>71</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM J. GOODWIN</u>		14. MOTHER'S MAIDEN NAME <u>MARY FLUSH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>705-10-9707</u>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH					
<p><u>410.9 I</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>MARCH 4</u> 19 <u>70</u> to <u>APRIL 3</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>APRIL 3</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>T.H. Lin</u>		23B. DATE SIGNED <u>4/3/70</u>		23C. PHYSICIAN'S NAME (Type) <u>T.H. LIN</u>	
23D. ADDRESS <u>100 N. Broadway</u> <u>BALTO, MD 21201</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>4/7/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Lin</u> ADDRESS <u>2331 Jefferson St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

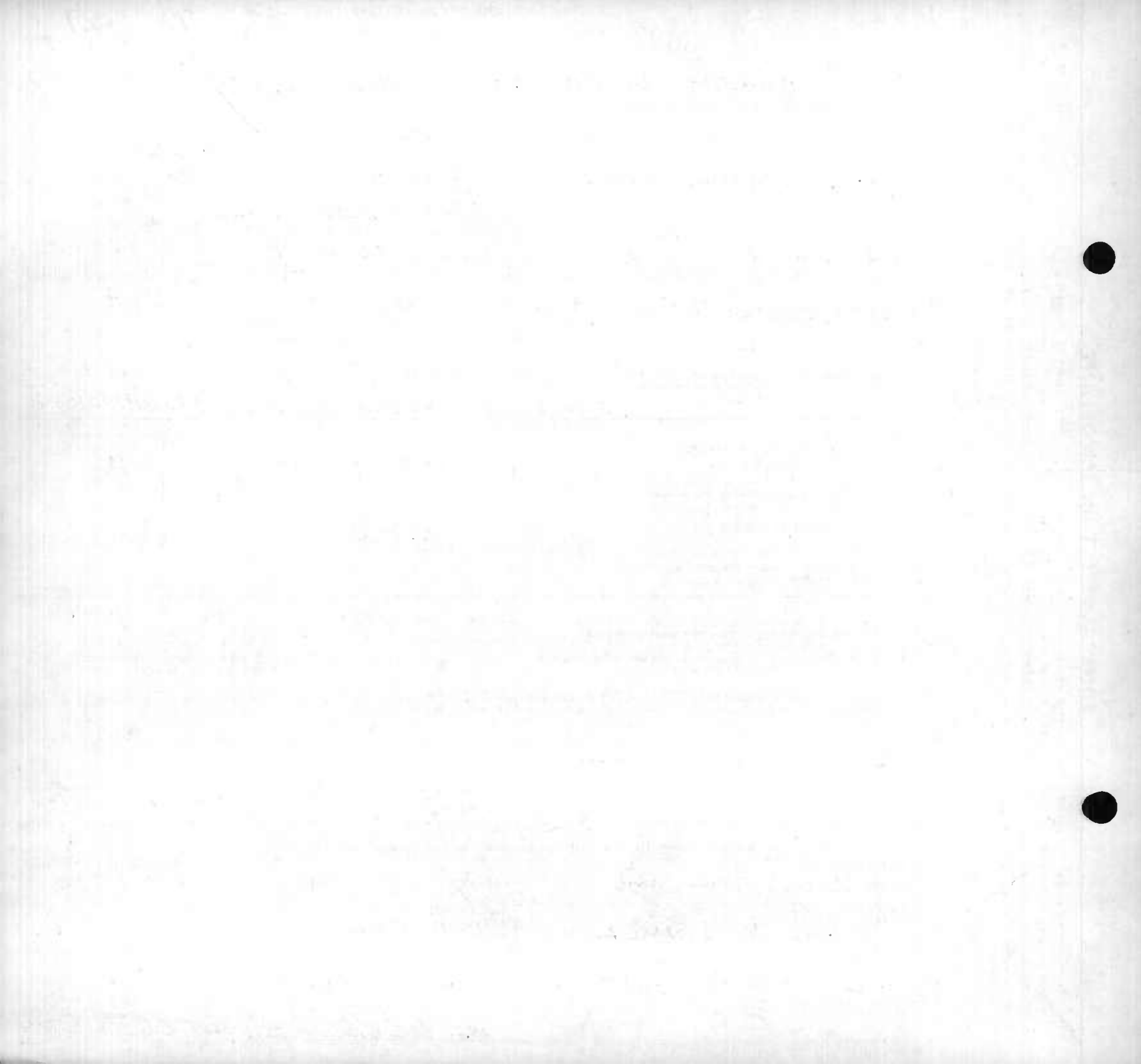
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3626	
BIRTH NO. S-400 70 3626		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WILBUR R. SEWELL		2. DATE AND HOUR OF DEATH MARCH 29, 1970 5:22 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEM. HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD B. COUNTY 9-02	
		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1521 E. 36th St.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-20-1906
		9. AGE (In years lost birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COST ACCOUNTANT		10B. KIND OF BUSINESS OR INDUSTRY AM. BANK STAT. CO.	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-9953	
		17. INFORMANT MARY E. SEWELL	
		ADDRESS 1521 E. 36th ST	
18. 398X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Acute cardiac failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rheumatic heart disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 1967 to March 24, 1970 , that (I) (we) lost saw the deceased alive on March 23, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.			
23A. SIGNATURE D. Allan Spier		23B. DATE SIGNED 3/31/70	
23C. PHYSICIAN'S NAME (Type) D. Allan Spier		23D. ADDRESS 3615 Chestnut Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-2-70	
24C. NAME OF CEMETERY or CREMATORY ST. MARY'S		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Paul E. Blum		25D. ADDRESS 3615 Chestnut Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3627	
<div style="display: flex; justify-content: space-between;"> T-620 70 3627 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ROBERT G. TRACEY		MARCH 29, 1970 10 30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
HOOD NURSING HOME			MD 27-31		
90			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			BALTO YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			3808 BIDDISON LANE		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-4-1886	83	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
TRANSIT OPERATOR		N.Y. ELEVATED		MD	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		158-10-6130		MRS NORMA V. LINDSAY 3808 BIDDISON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			ASHD		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II			Levee Emphysema		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3/23/1967 to 3/29/1970, that (I) (we) lost saw the deceased alive on 3/29/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Adnan M. Sonmez				3/31/1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Adnan M. Sonmez				10 11 Frederick Rd. Bal. Md 21228	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		4-2-70		BALTO. NATIONAL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 7 1970		Robert E. J. [Signature]		Paul E. [Signature]	
				ADDRESS	
				3615 Chestnut Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-240		70 3628		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3628	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>James Mc Cauley</u>			
2. DATE AND HOUR OF DEATH <u>4-1-70</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1102</u>				FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital</u>			
C. CITY OR TOWN <u>BALTIMORE</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>524 N. CHARLES ST</u>							
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-19-13</u>	
9. AGE (in years last birthday) <u>56</u>		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>HUTZLER BROS.</u>			
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>GEORGE MC CAULEY</u>				14. MOTHER'S MAIDEN NAME <u>CARRIE HOOD</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>FRIEND MR HUNLEY</u>	
18. <u>4-12-31</u>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<u>MURAL OLD MYOCARDIAL INFARCTION; THROMBUS LV. 10 yrs</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> 19 <u>70</u> to <u>4/1</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/1</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert J. Rosensteel M.D.</u>				23B. DATE SIGNED <u>4/1/70</u>		23C. PHYSICIAN'S NAME (Type) <u>ROBERT J. ROSENSTEEL M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>4-4-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	
24D. LOCATION <u>BALTO MD</u>				24E. NAME OF REGISTRAR <u>Paul E. Chumowich Jr.</u>		24F. ADDRESS <u>3615 Chestnut Ave.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Paul E. Chumowich Jr.</u>	



FUNERAL DIRECTOR: IMPORTANT

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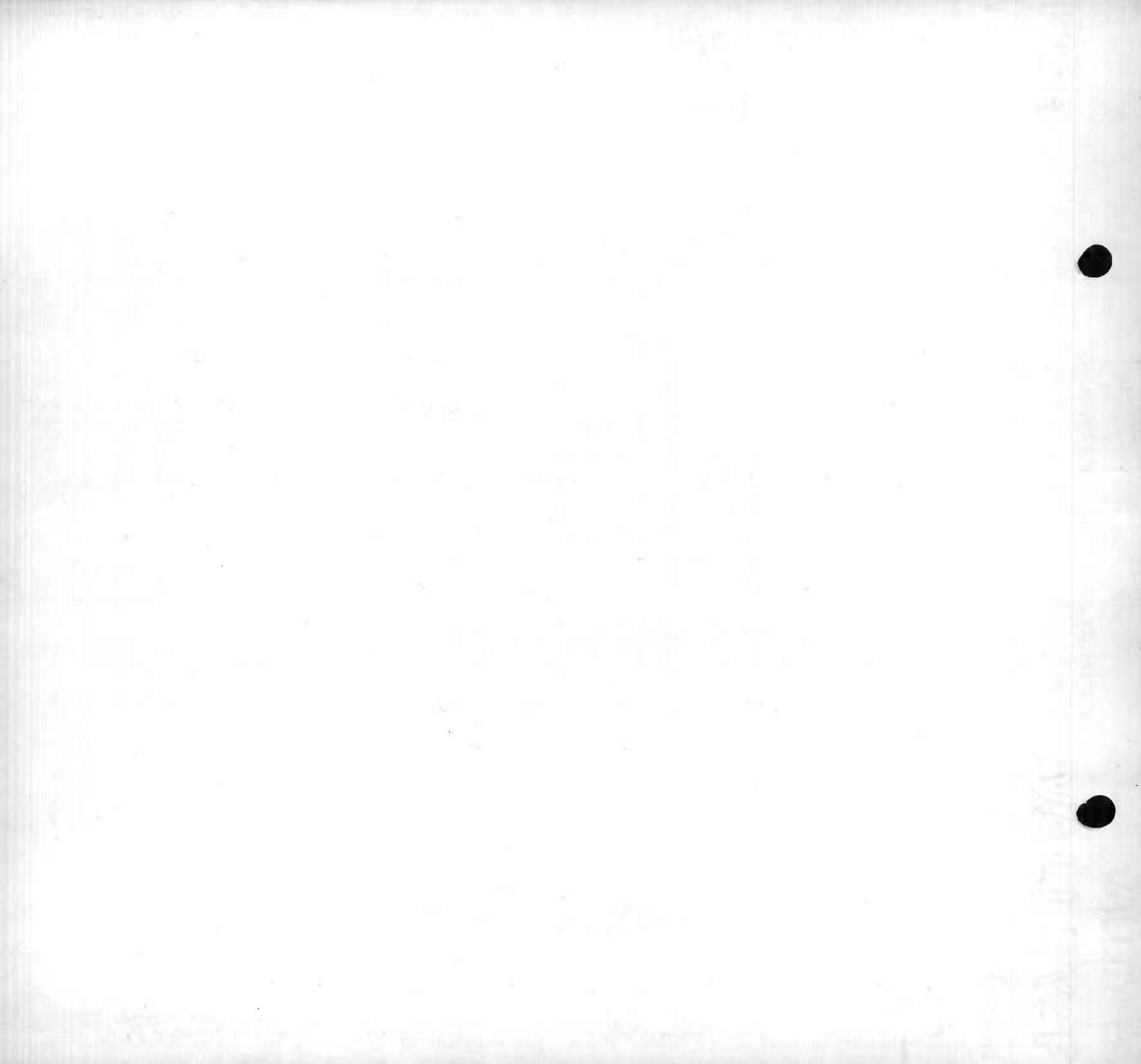
S-152 70 3629		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 270 3629	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARIE SPENCE		2. DATE AND HOUR OF DEATH 3-28-70 10 30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE: MARYLAND B. COUNTY: BALTIMORE CITY		C. CITY OR TOWN: BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 3939 ROLAND AVENUE 13-07	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-95	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JOHN MINNICK		14. MOTHER'S MAIDEN NAME MARTHA OBLER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT FLORENCE PALMER 3939 ROLAND AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH CARDIOPULMONARY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BLADDER CARCINOMA, PROTEUS (B) DUE TO, OR AS A CONSEQUENCE OF: MRABILIS SEPTICEMIA (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 1961 to 3-28-1970 that he (we) last saw the deceased alive on 3-28-1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.		23A. SIGNATURE J. SYLVESTER		23B. DATE SIGNED 3-28-70	
23C. PHYSICIAN'S NAME (Type) J. SYLVESTER		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-1-70		24C. NAME OF CEMETERY OR CREMATORY MT OLIVET	
24D. LOCATION (City, town, or county) (State) BALTO MD		25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Paul E. Heston, Jr.	
25C. FUNERAL DIRECTOR Paul E. Heston, Jr.		25D. ADDRESS 3615 Chestnut Ave			

11-2

FUNERAL DIRECTOR: IMPORTANT

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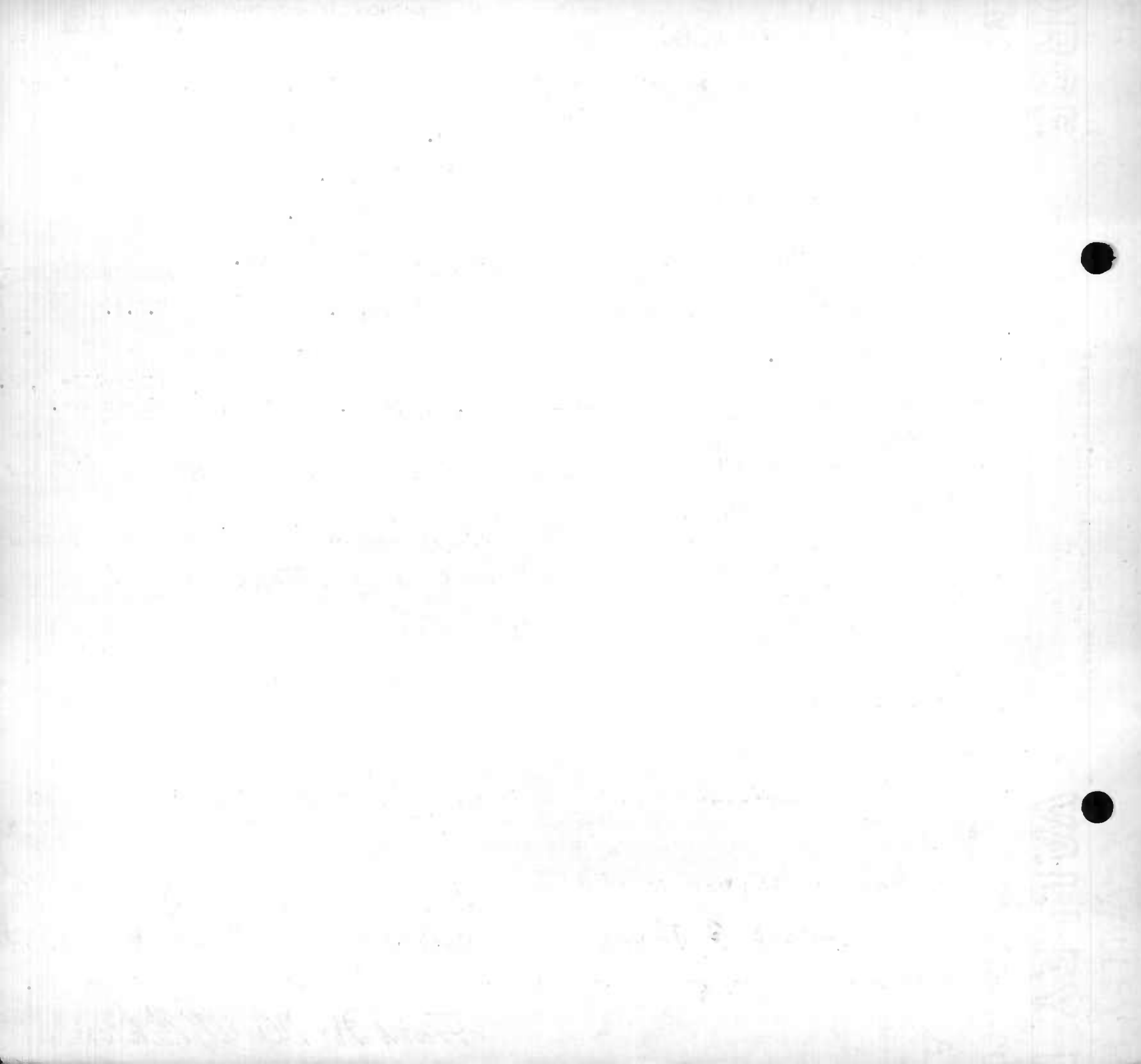
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3630	
B-235 70 3630		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BOSTON, MAYETTA K.		2. DATE AND HOUR OF DEATH 3/28/70 4:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 13-38			
FULL NAME OF HOSPITAL OR INSTITUTION USPHS HOSPITAL		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
X BALTIMORE		E. STREET AND NUMBER 3608 EDGE GREEN AVE			
5. SEX FEM.	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/19	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES E. PEARL		14. MOTHER'S MAIDEN NAME RUE RICE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO -		16. SOCIAL SECURITY NO. ?		17. INFORMANT CLARK E. BOSTON	
18. 200.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gastrointestinal hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Leticulum cell sarcoma DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/24 19 70 to 3/28 19 70 , that (I) (we) last saw the deceased alive on 3/28 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald E. Beaudoin MD				23B. DATE SIGNED 3/28/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-1-70		24C. NAME of CEMETERY or CREMATORY LAKEVIEW MEM. PARK	
24D. LOCATION CARROLL CO		24E. ADDRESS			
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR Paul C. Chenoweth	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
S-536 70 3631		CERTIFICATE OF DEATH		70 3631	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Jennie Catherine Schneider		April 2, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		A. STATE		B. COUNTY	
		Md.		Baltimore C	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Pikesville, Md.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		114 Waldron Ave.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 4, 1901	68 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Elsworth H. Evans		Lena Mae Spruess Sauers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		219-16-6705	
		Mr. Charles A. Schneider, 114 Waldron Ave.		Pikesville 8, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Coronary occlusion 2 hours	
		(B) DUE TO, OR AS A CONSEQUENCE OF:		Myocardial infarct - C.V.D. 14 months	
		(C) DUE TO, OR AS A CONSEQUENCE OF:		adrenal depletion 7	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		arthritis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from May 19, 1969 to April 2, 1970, that (I) (the) last saw the deceased alive on April 2, 1970 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Grace G. Jones, M.D. F.A.C.S.		April 3-1970			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
GRACE G. JONES		WALKER AVE. PIKESVILLE 8, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	April 6, 1970	Woodlawn Cemetery		Woodlawn Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
APR 7 1970	Robert E. Taylor, Jr.	Frank H. Newell, Pikesville 8, Md.			

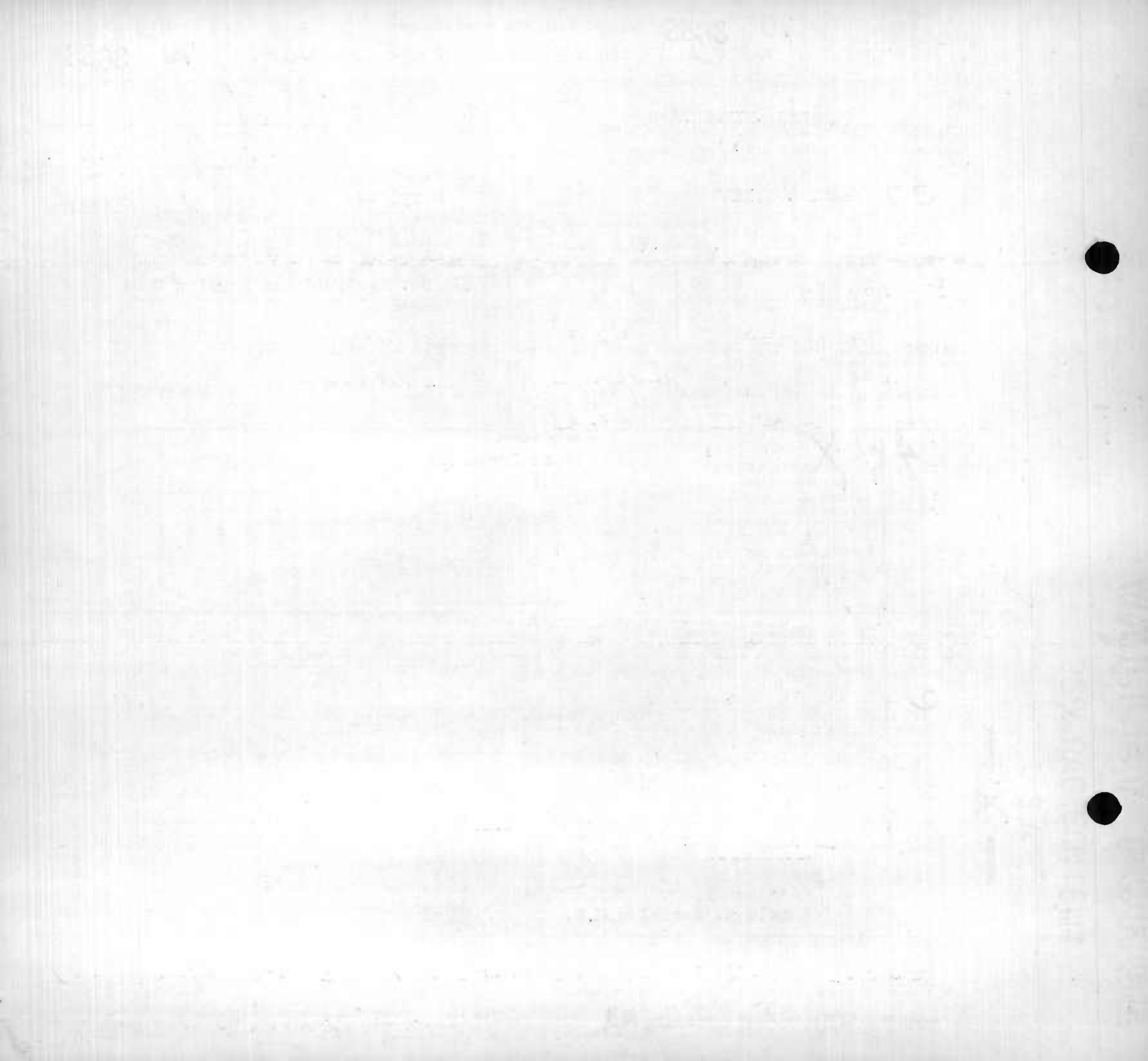


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P-520		70 3632		BALTIMORE CITY HEALTH DEPARTMENT		70 3632	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Pinnick, Ida I.				2. DATE AND HOUR OF DEATH 4-4-70 5:45 P.M. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital Caton & Wilkens Ave.				A. STATE Maryland B. COUNTY Howard Co. 63-00			
				C. CITY OR TOWN Jessup		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER Rt. 175 Howard County Box 424			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-94	9. AGE (in years last birthday) 75	10. Under 1 Year Months Days Hours Min.	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Hat Factory		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Sullens				14. MOTHER'S MAIDEN NAME Louise Mielke			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-3721-A		17. INFORMANT Frederick Pinnick		ADDRESS Rt. 175 Howard County	
18. CAUSE OF DEATH 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Acute Pericarditis - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Congestive Failure. 104 - Hyertensive A-S CVD. 104 - II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Congestive Failure. (B) DUE TO, OR AS A CONSEQUENCE OF: 104 - (C) 104 -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 -	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nately medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-25-1960 to 3-30-1970 that (I) (we) last saw the deceased alive on 3-30-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alexander Luyia MD				23B. DATE SIGNED 4-4-70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-7-70		24C. NAME of CEMETERY or CREMATORY Meadowridge Pk.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR Shelburne Funeral Home		ADDRESS 3218 Jackson St.	



1		70 3633		BALTIMORE CITY HEALTH DEPARTMENT	
H-431		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 3633	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
CHARLES HILDEBRAND		3. DATE PRONOUNCED DEAD		Month Day Year Hour March 30, 1970 4:05 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
37 MERCY HOSPITAL		Maryland		1102	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN	D. INSIDE CITY LIMITS?	
Male	White		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
5-20-84	86	MARYLAND		U.S.A.	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
Unknown		Unknown		Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
yes W.W.I		None			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Lobar Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
481 X I					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
2				yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Ronald N. Kornblum, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		4/1/70	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-2-70		London Nat'l Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 7 1970		R. E. Taylor, M.D.		WM. J. Tickner & Sons North & Penn Ave	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HOWARD LINE		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 30 70 11:00 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 6313 Toone St.		3. DATE PRONOUNCED DEAD Month Day Year Hour March 30, 1970 11:00a M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 11-12-1899		10. AGE (In years last birthday) 70	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? LINE		14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 26-36	
15. MOTHER'S MAIDEN NAME JULIA A. ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 315-01-9905		18. INFORMANT GORDON DORR	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.4 I Arteriosclerotic cardiovascular disease		20. DATE OF OPERATION 2	
21. AUTOPSY? (Yes or No) Partial		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
25. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		26. HOW DID INJURY OCCUR?	
27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		28. DATE	
29. NAME OF CEMETERY or CREMATORY		30. LOCATION (City, town, or county) (State)	
31. DATE REC'D BY HEALTH DEPT.		32. NAME OF REGISTRAR	
33. FUNERAL DIRECTOR		34. ADDRESS	

50-304

UNITED STATES DEPARTMENT OF JUSTICE

11-13-1941

TO THE ATTORNEY GENERAL
FROM THE DIRECTOR, FBI

RE: [illegible]
[illegible]

11-13-1941
BUREAU OF INVESTIGATION

TO THE ATTORNEY GENERAL
FROM THE DIRECTOR, FBI

RE: [illegible]
[illegible]

11-13-1941
BUREAU OF INVESTIGATION

TO THE ATTORNEY GENERAL
FROM THE DIRECTOR, FBI

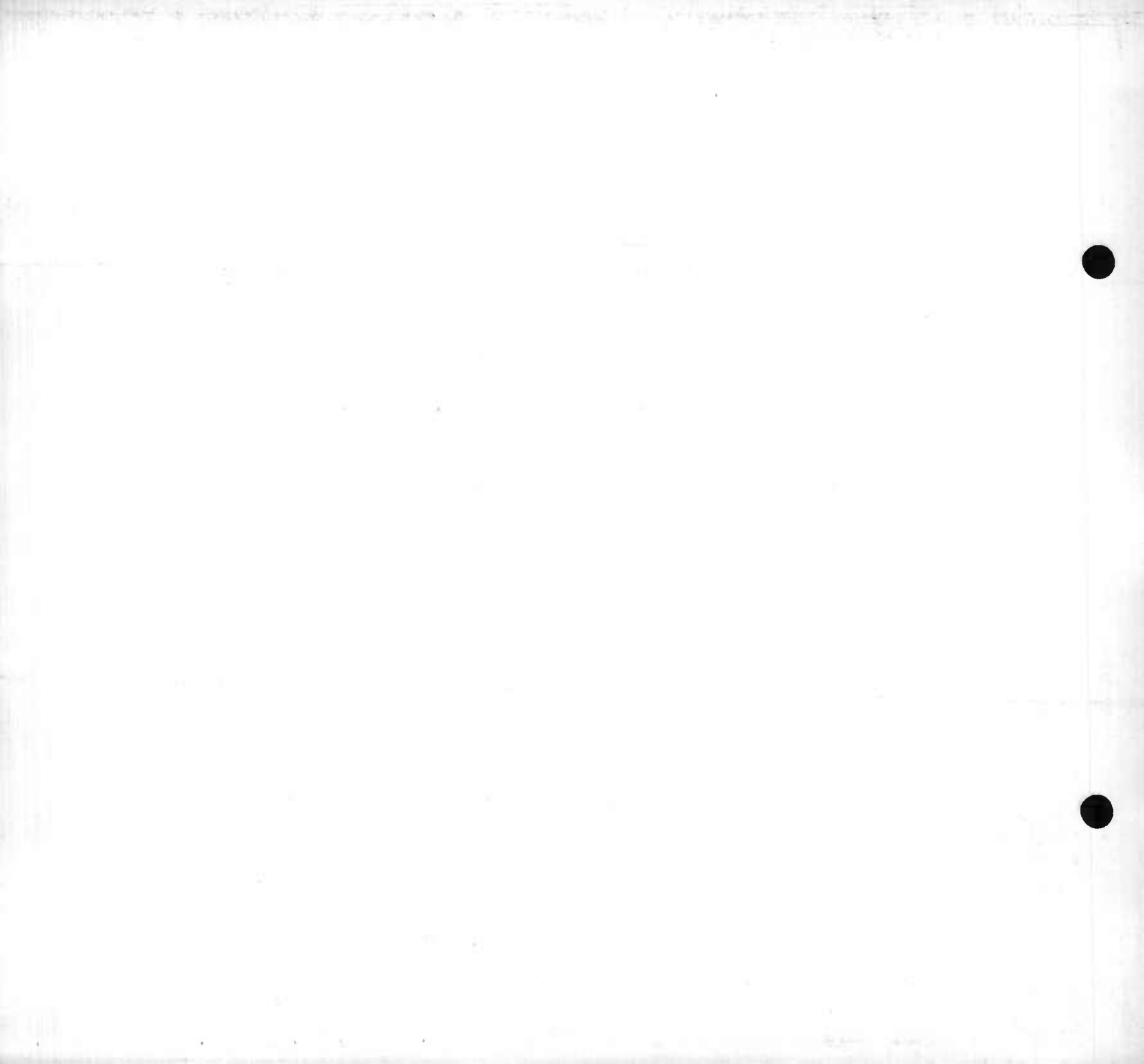
RE: [illegible]
[illegible]

11-13-1941
BUREAU OF INVESTIGATION

TO THE ATTORNEY GENERAL
FROM THE DIRECTOR, FBI

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

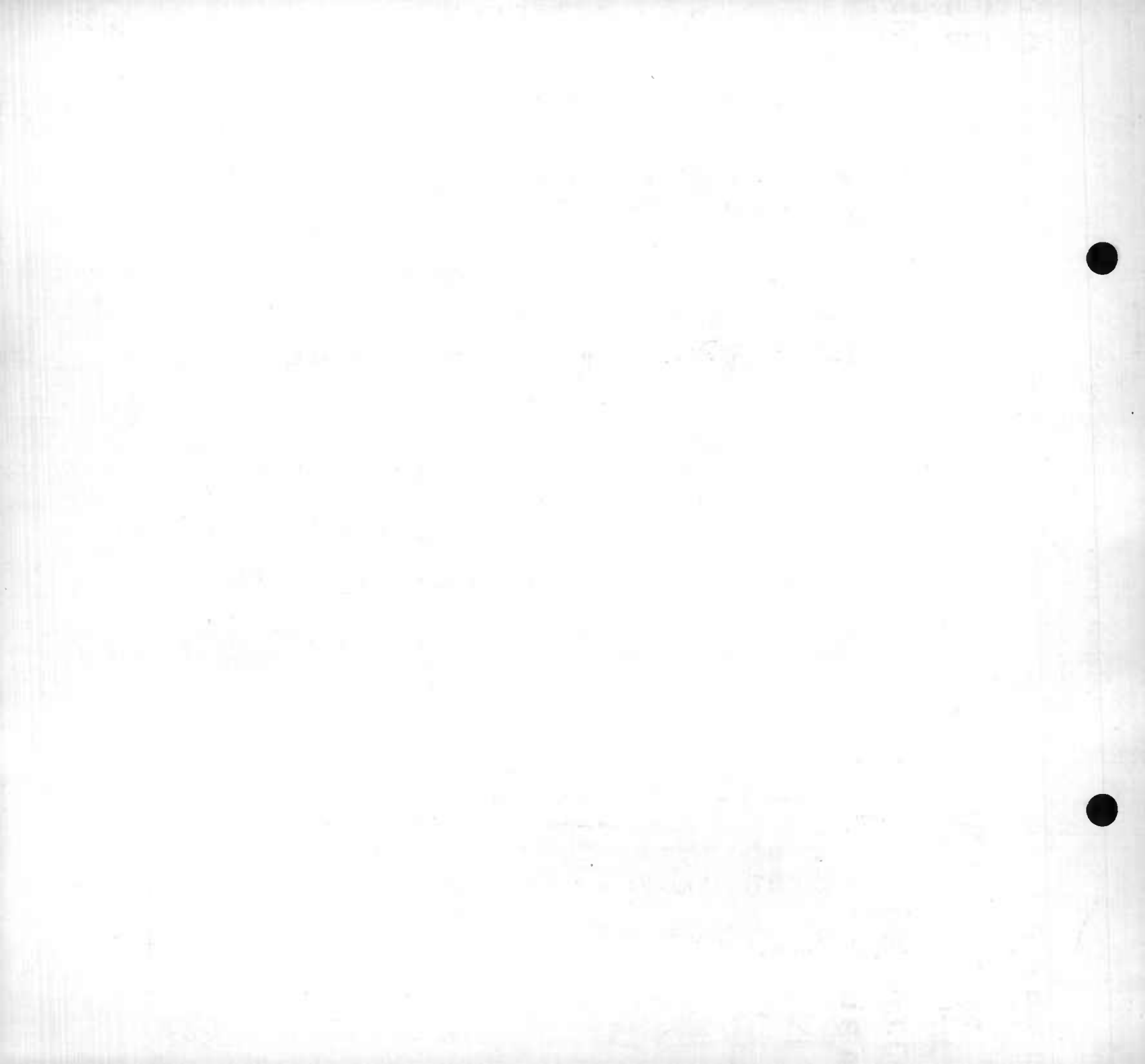
H-616 70 3635		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3635	
BIRTH NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Leta L Harper</u>			2. DATE AND HOUR OF DEATH <u>4/5/1970 14:50 p. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland General Hosp.</u>			4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hosp.</u>			C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3/5/1895</u> 9. AGE (In years last birthday) <u>75</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>
13. FATHER'S NAME <u>Edwin Gray</u>			14. MOTHER'S MAIDEN NAME <u>Minnie Porter</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>215 22 2824</u>		17. INFORMANT <u>Mrs. Myra O. Littleton</u>
			ADDRESS <u>8204 Guntree Drive 21222</u>		
18. <u>199.0 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Ca</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) <u>Septicemia (Staph.)</u> (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/7</u> 19 <u>70</u> to <u>4/5</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/5</u> 19 <u>70</u> and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael C. [Signature]</u>			23B. DATE SIGNED <u>4/5/70</u>		23C. PHYSICIAN'S NAME (Type) <u>MD. General Hospital</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4/8/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>	
				ADDRESS <u>3000 E. Baltimore St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
7-460 70 3636					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Joseph Zeller					235 4/4/70				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY				
Marbor View Nursing home					Md AA Baltimore, 53-00				
90 Light Street Baltimore					C. CITY OR TOWN D. INSIDE CITY LIMITS?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER									
1244 Maple Avenue									
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/17/84	86					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Grocery - Retail			Self-employed			Baltimore County		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
John Van Jas Zeller					Anne Kohl				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS		
No			2204644567	Mabel E. Simmonds Zeller			1244 Maple Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES					Cardiac Arrest				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					A.S.C.D. Heart Block				
					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					Generalized art. scl.				
					(C) Cerebral Art. Sclerosis				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					Carcinoma of Prostate - Postop.				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0					No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from Jan 1970 to 4/4 1970, that (I) (we) last saw the deceased alive on 3/15 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Kenneth Krulevitz M.D.					4/6/70				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Kenneth Krulevitz M.D.					115 W. Monument St. Baltimore, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		April 9, 1970		London Park Cemetery		Baltimore Maryland			
25A. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR				
Blair E. Zeller, M.D.					Ambrose, Inc. 1328 Sulphur Spring Rd.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-320 70 3637				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3637	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Watts, Edgar O.</u>				2. DATE AND HOUR OF DEATH <u>4/4/70 - 8 30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Baltimore, Md.</u>		A. STATE <u>Md.</u>		B. COUNTY <u>4613 Park Heights Ave</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>Mt. Sinai Nursing Home</u>		<u>4613 Park Heights Ave</u>	
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/92</u>	9. AGE (in years last birthday) <u>78</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Welder</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Edgar P. Watts</u>				14. MOTHER'S MAIDEN NAME <u>Clara B. Thomas</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-07-6427</u>		17. INFORMANT <u>Edgar A. Watts</u>	
				ADDRESS <u>21227</u>			
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <u>CVA.</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>4/4</u> 19 <u>70</u> to <u>4/4</u> 19 <u>70</u> that (I) <u>we</u> last saw the deceased alive on <u>4/4</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. Stokh Margolis MD.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/4/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. Stokh Margolis MD.</u>				23D. ADDRESS <u>Sinai Hospital</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>04/08/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore City, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Walters Funeral Home Pratt & Stricker</u>			
				ADDRESS <u>Sto.</u>			

address was 4615 Pennington Ave.
Called N.H. CT

Integrité n'est
pas une vertu
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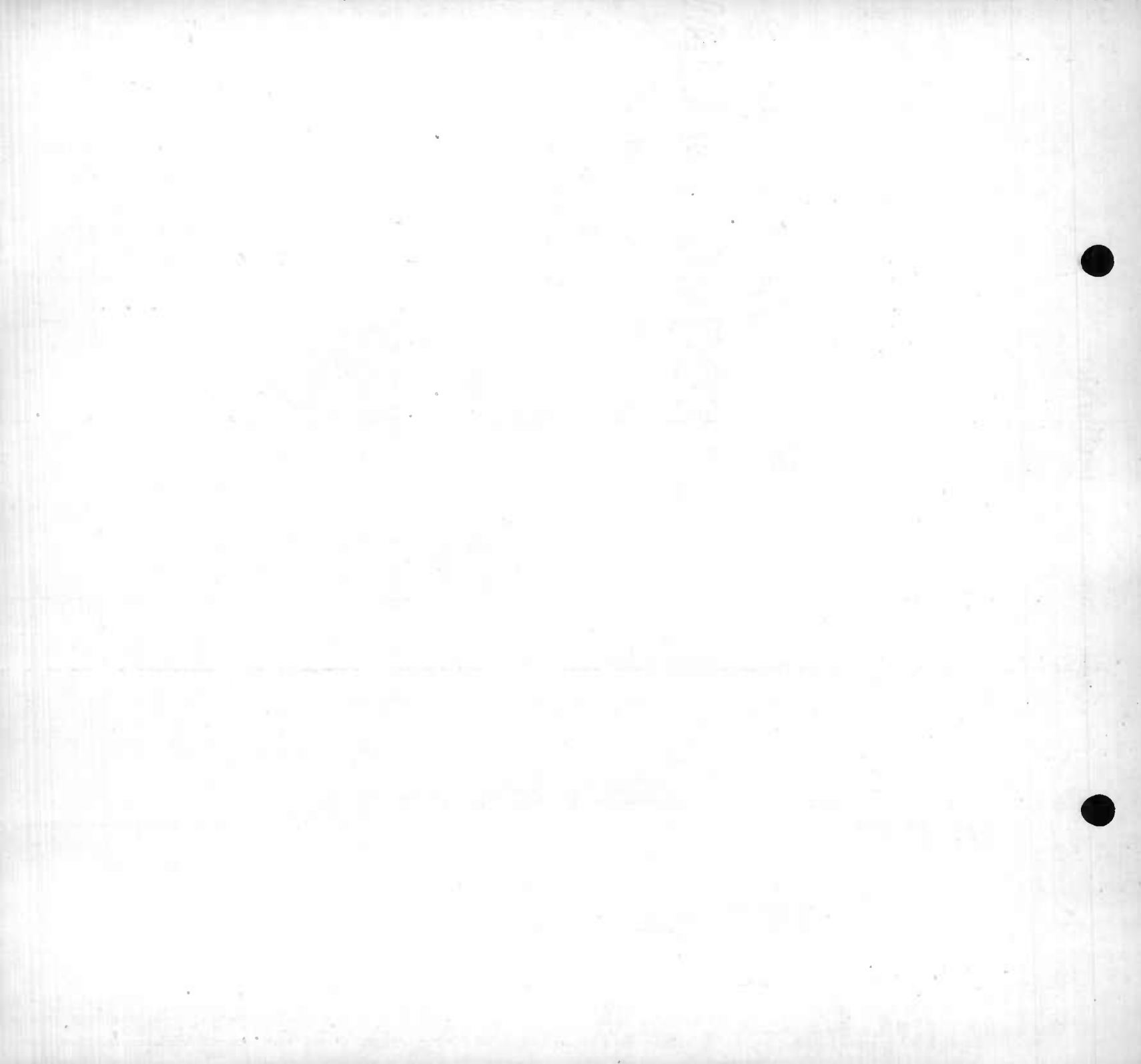


On 24/11/2016
à 14h00
Integrité n'est
pas une vertu

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3638
BIRTH NO. 1. NAME OF DECEASED (Type or Print) JOHN NICHOLAS KACANIS		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> March 30, 1970 11:00 A. M. </div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION 800 S. Quail Street Baltimore, Md. </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE Md. </div> <div> B. COUNTY Baltimore </div> </div> C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9-15-97		9. AGE (In years last birthday) 72		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant owner
10B. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Nicholas		14. MOTHER'S MAIDEN NAME Sophia		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 194-05-2374		17. INFORMANT Mrs. Helen Kacanis
ADDRESS 800 S. Quail Street, Baltimore, Md.				
18. CAUSE OF DEATH				
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> Coronary Thrombosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension, Peptic ulcer (C) </div> </div>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE SAMUEL STERN, M.D.				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) Samuel Stern M.D.				23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-3-70		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR 		25C. FUNERAL DIRECTOR Nicholas T. Matthews
				ADDRESS 3021 Eastern Ave., Baltimore, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-654		70 3639		BALTIMORE CITY HEALTH DEPARTMENT		X		70 3639		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Bromley Bertha E.</i>				2. DATE AND HOUR OF DEATH <i>3/30/70 12^{PM}</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Kent Co.</i>				C. CITY OR TOWN <i>Rock Hall</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>48 Maryland General Hospital</i>		E. STREET AND NUMBER <i>Rte 2, Kent County</i>								
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-01-07</i>	9. AGE (in years last birthday) <i>62</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Dlugoborski</i>			14. MOTHER'S MAIDEN NAME <i>Pauline Redyk</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>216-03-8891</i>	
17. INFORMANT <i>Jesse Bromley, Rout 2, Rock Hall, Md.</i>			ADDRESS			18. <i>403X I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>acute renal failure</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>renal arteriosclerosis</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>chronic hypertension</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>23 d.</i>	
19A. DATE OF OPERATION <i>3/30/70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that this (this hospital) attended the deceased from <i>3/7/70</i> to <i>3/30/70</i> and that we (we) lost saw the deceased alive on <i>3/30/70</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) not view the body after death.			23A. SIGNATURE <i>[Signature]</i>			
23B. DATE SIGNED <i>3/30/70</i>		23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i>		23D. ADDRESS <i>[Signature]</i>		23E. NAME OF REGISTRAR <i>[Signature]</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-2-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>APR 7 1970</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>Nicholas T. Matthews</i>		25D. ADDRESS <i>3021 Eastern Ave., Baltimore, Md.</i>				

Page 2

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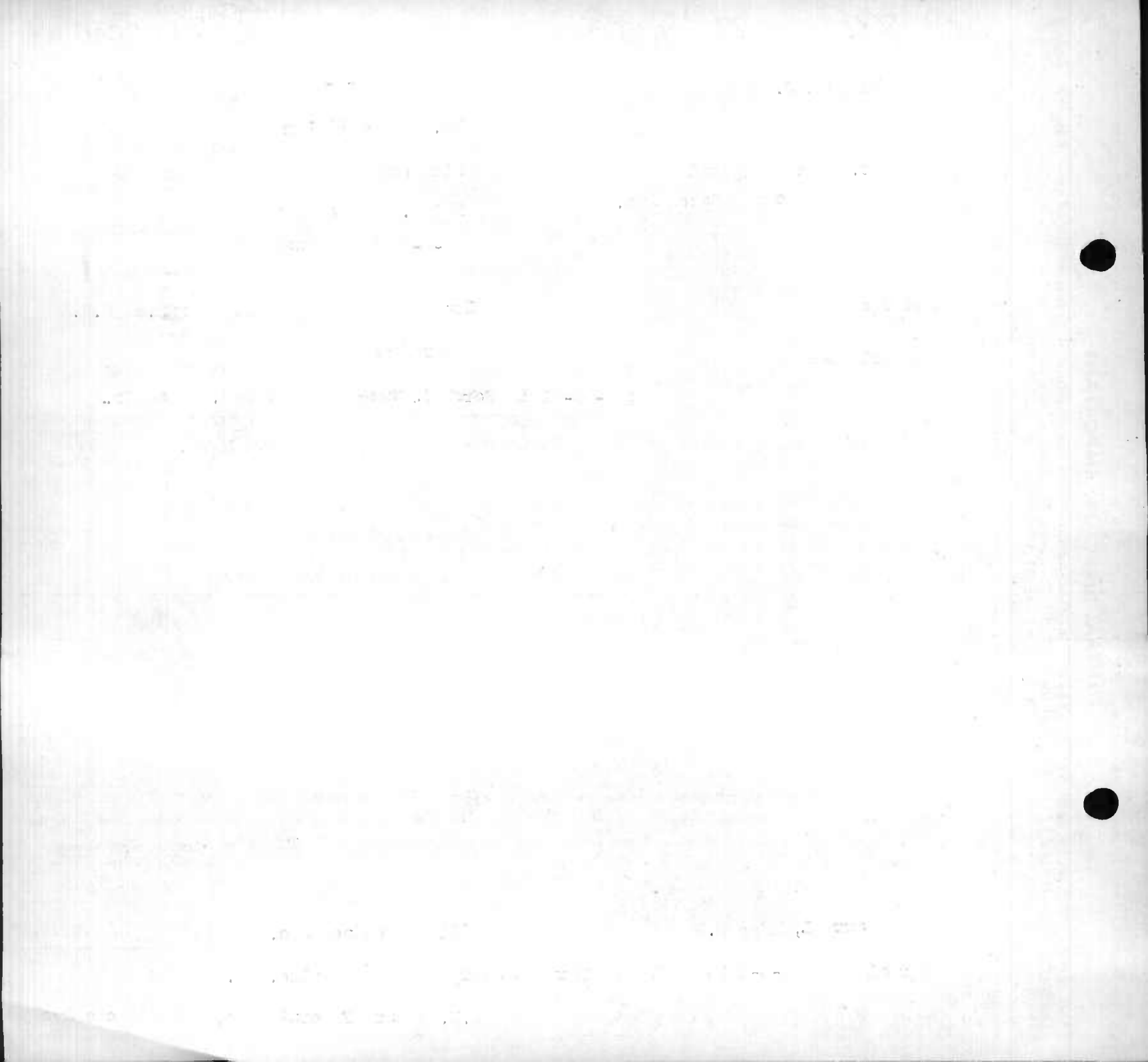
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

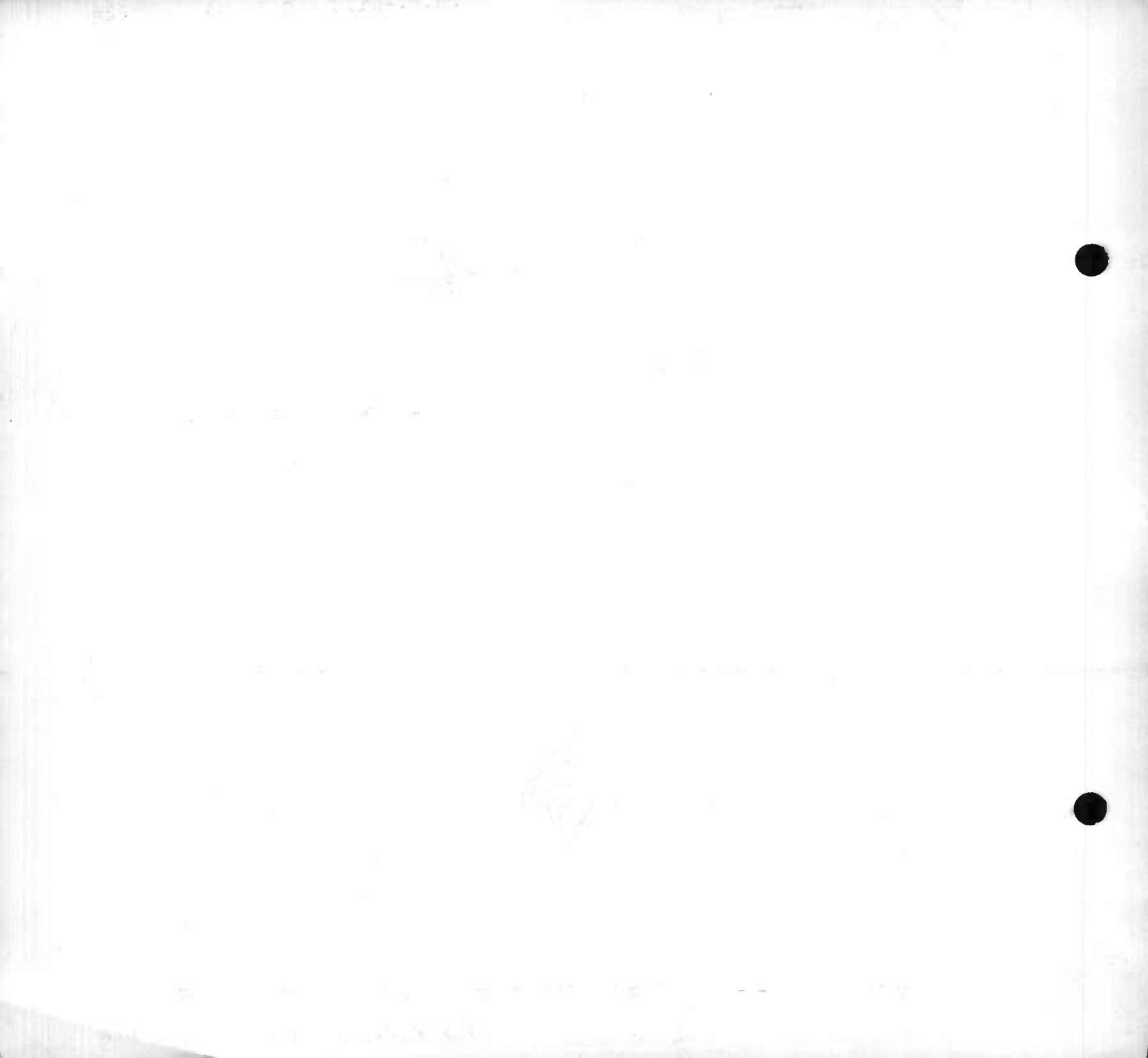
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3640
BIRTH NO. C-200		70 3640 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Vincent J. Coco		2. DATE AND HOUR OF DEATH 4-1-70 9:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore		5. CITY OR TOWN Baltimore		
6. FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital Wilkins & Caton Ave.		7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
8. SEX M		9. RACE W		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
11. DATE OF BIRTH 8-1-1902		12. AGE (In years) 67 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14. BIRTHPLACE (State or foreign country) Italy		
15. FATHER'S NAME Angelo Coco		16. MOTHER'S MAIDEN NAME Serafina		
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO. 169-03-9161		
19. INFORMANT Sarah A. Coco		20. ADDRESS 546 S. Wickam Rd.		
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4-1-70 I acute coronary artery occlusion		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden		
23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary artery sclerosis C. Diabetes mellitus Arteriosclerotic Cardio Vasc. disease		24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
25. DATE OF OPERATION 0		26. CONDITION FOR WHICH OPERATION WAS PERFORMED		27. AUTOPSY? (Yes or No) No
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		31. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
32. HOW DID INJURY OCCUR?		33. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
22. I certify that (I) (this hospital) attended the deceased from 10-17-1960 to 4-1-1970, that (I) (we) last saw the deceased alive on 3-31-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Harry L. Knipp, M.D.		23B. DATE SIGNED 4-3-70		
23C. PHYSICIAN'S NAME (Type) Harry L. Knipp, M.D.		23D. ADDRESS 4116 Edmondson Ave. Balto, Md. 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-4-1970		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		
25B. NAME OF REGISTRAR W. E. Huber, M.D.		25C. FUNERAL DIRECTOR H. H. Hubbard Funeral Home, 4107 Wilkens Ave		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

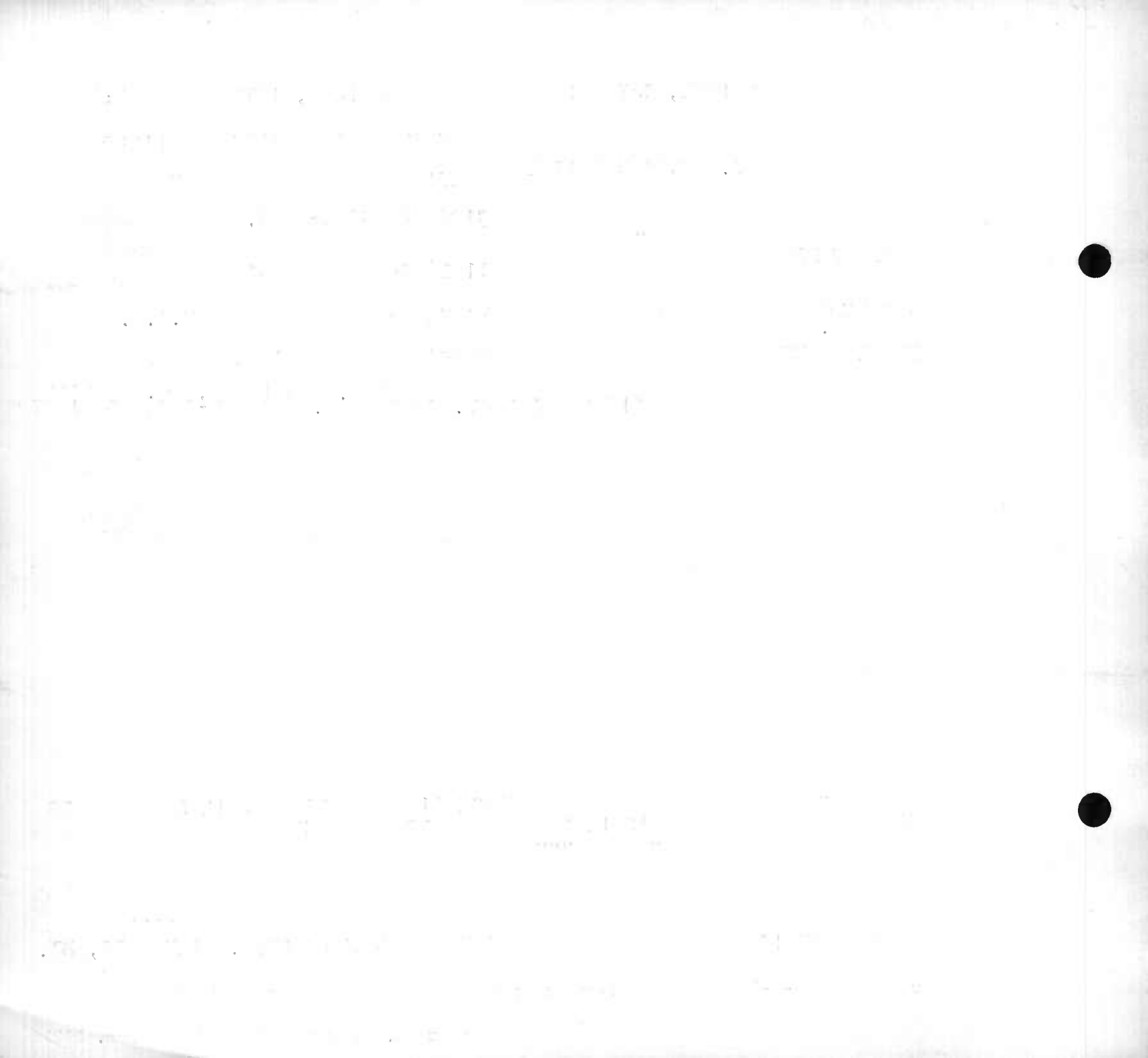
BALTIMORE CITY HEALTH DEPARTMENT				NS 70 SPS 3641	
CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ROGER S. CLAUSING</u>		2. DATE AND HOUR OF DEATH <u>3 April 1970</u> <u>15:10</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Tennessee</u> B. COUNTY <u>Knoxville</u>		C. CITY OR TOWN <u>Knoxville</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/4/36</u>	9. AGE (in years last birthday) <u>34</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
13. FATHER'S NAME <u>Stanley Clausing</u>		14. MOTHER'S MAIDEN NAME <u>Effie Young</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Windel-Howland Funeral Home, 1503 Offnere St.</u>	
18. <u>191X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRAIN Stem Astrocytoma</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>23 March 1970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BRAIN Tumor</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19 March 1970</u> to <u>3 April 1970</u> that (I) (we) last saw the deceased alive on <u>2 April 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edward D. Layue</u>				23B. DATE SIGNED <u>3 April</u>	
23C. PHYSICIAN'S NAME (Type) <u>Edward D. Layue</u>		23D. ADDRESS <u>University of Maryland Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-7-1970</u>		24C. NAME of CEMETERY or CREMATORY <u>Floral Hills Memorial Gardens</u>	
24D. LOCATION <u>Franklin Furnace, Ohio</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>H. H. Hubbard</u>		25D. ADDRESS <u>5741 Walling Lane</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

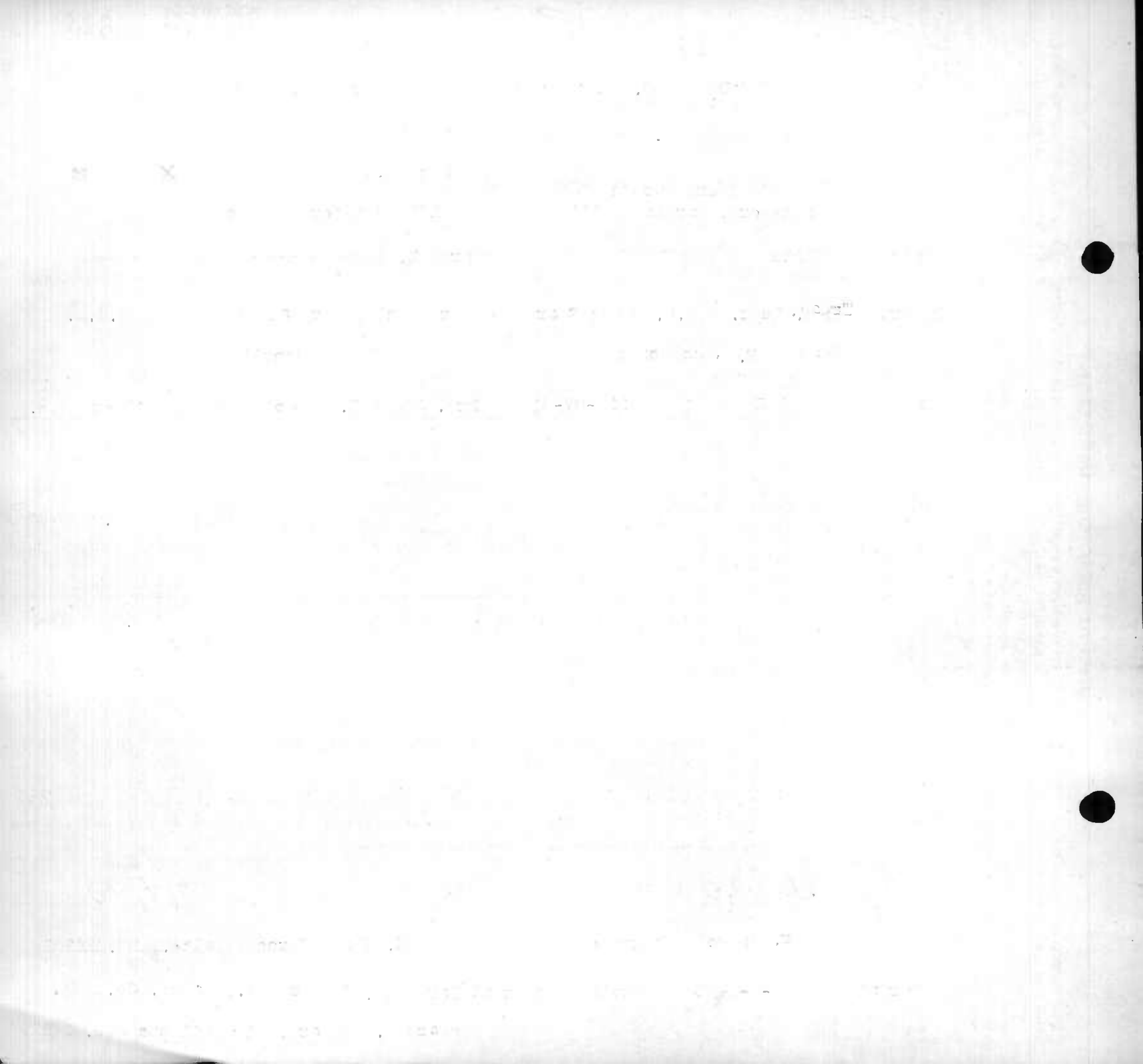
BALTIMORE CITY HEALTH DEPARTMENT				70 3642		70 3642	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
K-380 70 3642 KEIDEL, CATHERINE		APRIL 2, 1970		4:40AM		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40 ST. AGNES HOSPITAL				MARYLAND		BALTO CITY	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER							
3100 GEORGETOWN RD.							
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 Yr. Months	11. UNDER 24 Hrs. Days	12. UNDER 24 Hrs. Hours
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11 26 08	61			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				MARYLAND		U.S.A.	
13. FATHER'S NAME J.				14. MOTHER'S MAIDEN NAME			
GEORGE DIETZ				XXXXX) Mary Ruppel			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
				216 36 7187		AVES. BALTIMORE, MD ADDRESS 21229 ST. AGNES HOSP. RECORDS-CATON & WILKENS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				intra-aortic hemorrhage			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				(B) ? rupture aorta aneurysm			
				(C) ? increase in BP.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (1) (this hospital) attended the deceased from MARCH 31 19 70 to APRIL 2 19 70 that (1) (we) last saw the deceased alive on APRIL 2 19 70 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
George Patrick				April 2, 1970			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
GEORGE PATRICK				CATON & WILKENS AVES. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-6-1970		Holy Redeemer Cemetery		Baltimore, Maryland	
25A. DATE REC'D. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 7 1970		Howard H. Hubbard		4107 Wilkens Ave.		21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3643	
A-253 70 3643 BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOSEPH C. ASHMEADE			2. DATE AND HOUR OF DEATH April 3, 1970 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2610 Guilford Avenue Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 12-03 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2610 Guilford Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1895	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Treas. Dept.			10B. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard		
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Noah F. Ashmeade			14. MOTHER'S MAIDEN NAME Dolly Sterling		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> W W I			16. SOCIAL SECURITY NO. 220-07-4189		
17. INFORMANT Mrs. Addie I. Ashmeade, 2610 Guilford Ave.			ADDRESS 21218		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 153.1 + 1 250.9 CAUSE OF DEATH Carcinomatous (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of splenic flexure (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month Several Months Several Months		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes & Supraventricular tachycardia					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/3 1970 to 4/3 1970 , that (I) (we) last saw the deceased alive on 4/1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel Morrison				23B. DATE SIGNED 4/4/70	
23C. PHYSICIAN'S NAME (Type) Dr. Samuel Morrison				23D. ADDRESS 11 E. Chase Street, Balto., Md. 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-6-1970		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park Cem.	
24D. LOCATION (City, town, or county) (State) Taylor Ave., Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. APR 7 1970			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 3644	
X-540 70 3644 BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <u>Albert P. Kenly, Jr.</u>				2. DATE AND HOUR OF DEATH <u>4/3/70</u> <u>12:25 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2632</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4602 FOLEY AVE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/05</u>		9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Albert P. Kenly, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Fink</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-09-8254</u>		17. INFORMANT <u>MRS. MAY B. KENLY</u>		ADDRESS <u>(SAME)</u>
18. <u>492X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac asphyxia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>R. Pneumonia</u>			
				(C) <u>R. Pneumonia</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/29/1970</u> to <u>4/3/1970</u> that (I) (we) last saw the deceased alive on <u>4/3/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Leonard J. Ruck, Inc.</u>				23B. DATE SIGNED <u>4/3/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Union Memorial Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/7/70</u>		24C. NAME of CEMETERY or CREMATORY <u>PARKWOOD CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>2009 J. B. Ruck, Jr.</u>		25C. FUNERAL DIRECTOR <u>LEONARD J. RUCK, INC.</u>		ADDRESS <u>BALTO. MD. 21214</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3645	
<div>C-512 70 3645</div> <div>CERTIFICATE OF DEATH</div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Frank S. Campagna		2. DATE AND HOUR OF DEATH 4-4-70 2 ⁵ A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2745		
FULL NAME OF HOSPITAL OR INSTITUTION 00 6006 Glen Oak Avenue			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 6006 Glen Oak Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1894.	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auto Mechanic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? Italy					
13. FATHER'S NAME Joseph Campagna			14. MOTHER'S MAIDEN NAME Maria ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Mamie R. Campagna (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 433.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis 3 days (B) Cerebral arteriosclerosis 2 years (C) DUE TO, OR AS A CONSEQUENCE OF: Rheumatoid arthritis 12 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 to April 4, 1970, that (I) (we) last saw the deceased alive on April 3, 1970, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE R. Donald Jandorf				23B. DATE SIGNED 4-4-70	
23C. PHYSICIAN'S NAME (Type) R. Donald Jandorf				23D. ADDRESS 7403 Hartford Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/8/70.		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR John E. Kelly		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-256		70 3646		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3646	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				AMELIA WISNER			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 4/5/70 2:45 AM			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL 44				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2642 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4209 STANWOOD AVENUE			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-10-10	9. AGE (In years last birthday) 59 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME JOSEPH GIRALICO				14. MOTHER'S MAIDEN NAME PAULINE LABELLE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HUSBAND (Mr. Sherman Wisner) same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular malformation (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 3 19 70 to April 5 19 70 that (I) (we) last saw the deceased alive on April 5 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Victoria C. Gallardo MD				23B. DATE SIGNED 4/5/70		23C. PHYSICIAN'S NAME (Type) VICTORIA C. GALLARDO MD	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/9/70		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR LEONARD J. Ruck, Inc. BALTO. MD.		25D. ADDRESS 21214	

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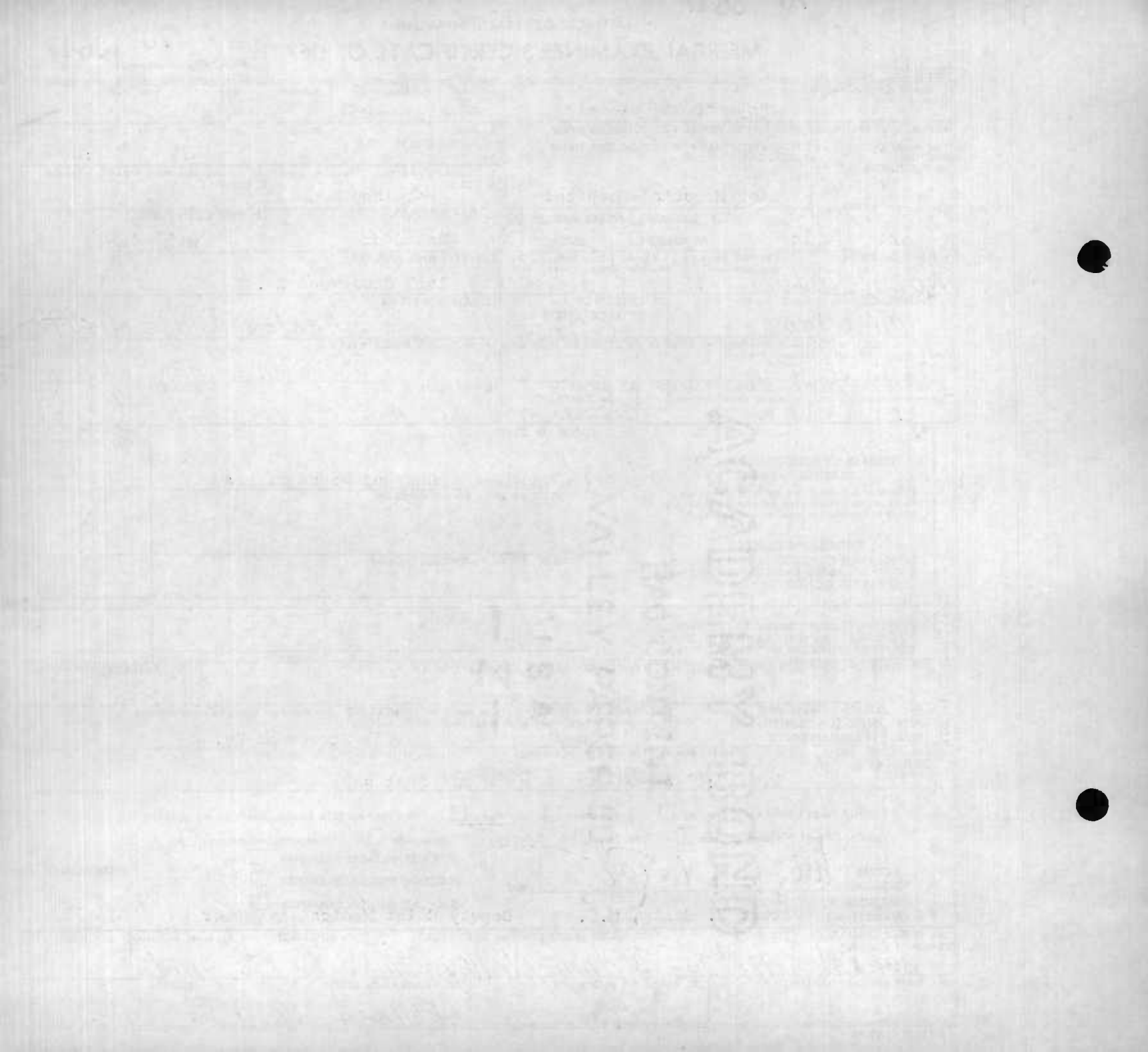
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3647

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Raymond Didszoneit		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 4 70 5:00 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 4 70 5:00 a.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov. 1, 1904		10. AGE (In years lost birthday) 65	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIRE SETTER		15. MOTHER'S MAIDEN NAME DORA MENKENS	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W W 2		17. SOCIAL SECURITY NO. 215-03-0571-A	
18. INFORMANT MRS. MINNA DIDSZONEIT		ADDRESS (SAME)	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E955 X1		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1613 Stonewood Rd.		22F. HOW DID INJURY OCCUR? shot self	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 4 4 70 12:01 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/4/70			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/8/70	
24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Cem.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC.		ADDRESS BALTO. MD. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 3648	
BIRTH NO. <u>S-625 70 3648</u>		REG. NO. <u>70 3648</u>	
1. NAME OF DECEASED (Type or Print) <u>SCROGGINS, MABEL</u>		2. DATE AND HOUR OF DEATH <u>April 2, 1970</u> <u>12:58</u> <u>A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u> <u>38</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1701</u>	
5. SEX <u>F</u>		6. RACE <u>N</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/7/11</u>	
9. AGE (in years last birthday) <u>58</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Scroggins</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Robinson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>chart</u>		ADDRESS	
18. <u>093.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Consecutive Ant. Failure / Myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Venereal Syphilis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>1 yr. (at least)</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 29</u> 19 <u>70</u> to <u>April 2</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>April 1</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Mark M. Doyle, MD</u>		23B. DATE SIGNED <u>April 2, 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>Mark M. Doyle, MD</u>		23D. ADDRESS <u>University of Md. Hospital Bldg. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/6/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL CEM.</u>		24D. LOCATION <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>R. E. Fisher, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		25D. ADDRESS <u>319 N. Broadway St</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3649</u>	
1. NAME OF DECEASED (Type or Print) <u>MR. CHARLES JOHNSON</u>		2. DATE AND HOUR OF DEATH <u>4/2/70</u> <u>10.55 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>1901</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hosp</u>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>229 N. Bruce St.</u>			
5. SEX <u>Female</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-05</u>	9. AGE (in years last birthday) <u>65</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Edward Brown</u>		14. MOTHER'S MAIDEN NAME <u>Louise Johnson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-12-3564</u>		17. INFORMANT <u>Viola Miller 1021 W. Fayette St.</u>	
18. <u>492X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Diffuse Vesicular Emphysema with cor Pulmonale</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> 19 <u>70</u> to <u>4/2</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mayuree Khongcharoen-suk, M.D.</u>				23B. DATE SIGNED <u>4/2/70.</u>	
23C. PHYSICIAN'S NAME (Type) <u>MAYUREE KHONGCHAROENSUK, M.D.</u>				23D. ADDRESS <u>Bon Secours Hosp. Baltimore, Md. 21223.</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/7/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		25D. ADDRESS <u>3199 Schomberg St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

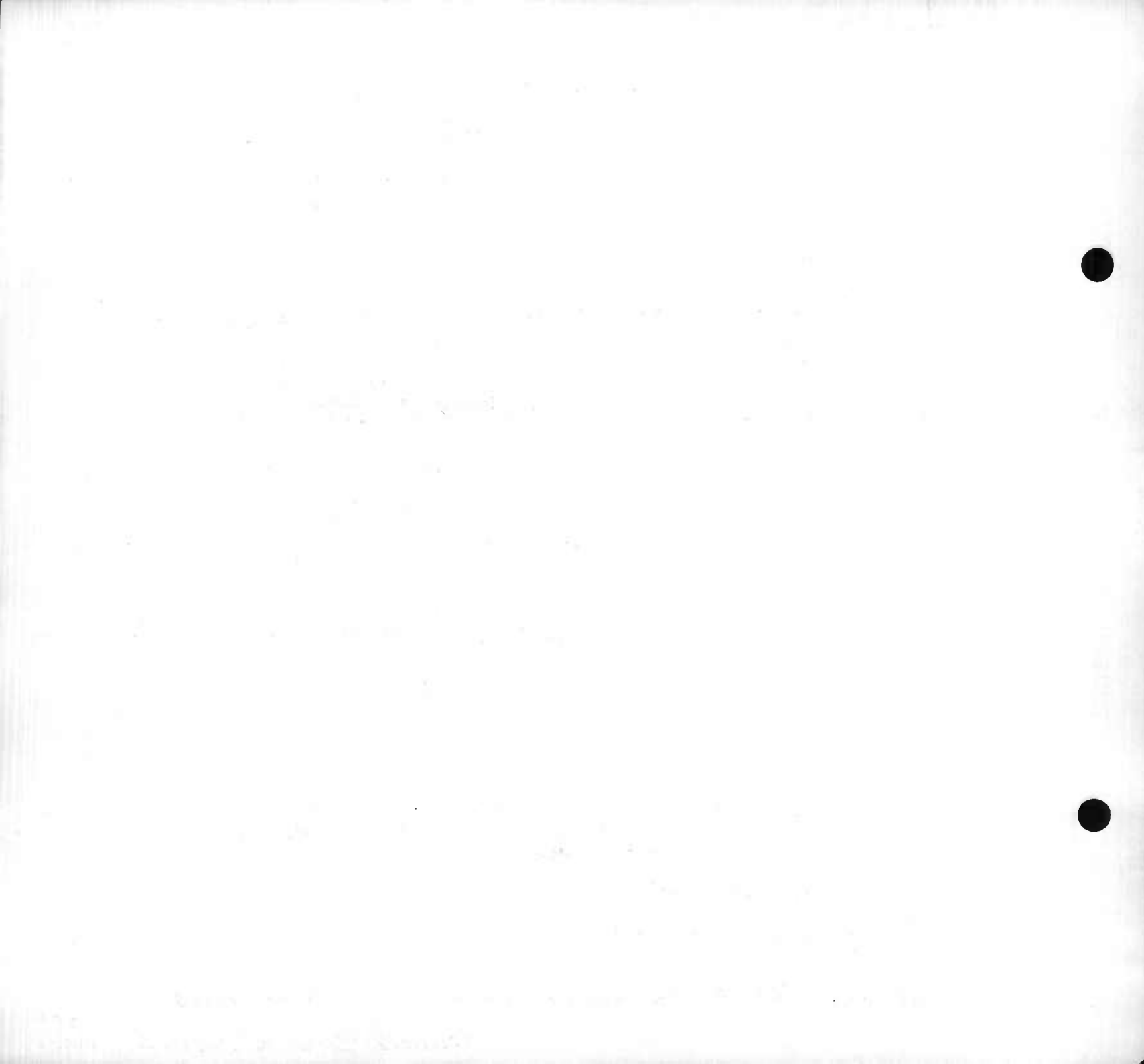
L-200		70 3650		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3650	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
				LEWIS, Jesse Essler				31 MARCH 1970 8:45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE DISTRICT OF COLUMBIA				B. COUNTY	
23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218				C. CITY OR TOWN WASHINGTON, D. C.				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4328 ALABAMA AVENUE, S. E.					
5. SEX MALE		6. RACE NEGROID		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12-1-19		9. AGE (In years last birthday) 50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME JOSEPH LEWIS				14. MOTHER'S MAIDEN NAME LOUISE CARRINGTON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 9-3-42 TO 2-14-46				16. SOCIAL SECURITY NO. 226-18-82-79		17. INFORMANT V A HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTO, MD 21218			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Edematous lungs DUE TO, OR AS A CONSEQUENCE OF: (B) Metastatic Carcinoma of esophagus DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 3/25/70				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstructive Carcinoma of esophagus		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (If (this hospital) attended the deceased from 19 MARCH 19 70 to 31 MARCH 19 70 that (If (we) last saw the deceased alive on 31 MARCH 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]				23B. DATE SIGNED 4/1/70					
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS 3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/3/70		24C. NAME of CEMETERY or CREMATORY Harmony Memorial Park		24D. LOCATION Landover, pr. Geo. Md.		(Total)	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR Robert H. Snowden		ADDRESS Rockville, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> A-25470 3651 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> X REG. NO. 70 3651 </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANGELINA AGNELLO		2. DATE AND HOUR OF DEATH April 1, 1970 10:47 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MASS. B. COUNTY USA		5. CITY OR TOWN METHUEN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHILDREN HOME HOSPITAL		E. STREET AND NUMBER 147 Jackson St.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/14/07	9. AGE (In years last birthday) 62	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) USA - MASS	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Michael Pandolino		14. MOTHER'S MAIDEN NAME Grace Marissi	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 033-09-1028		17. INFORMANT Cora Zuercher ADDRESS (bought)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4/10.9 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: acute diaphragmatic hernia</p> <p>(B) arteriosclerotic heart disease</p> <p>(C) Symptomatic Atrial Fibrillation</p>		<p>4 hours</p> <p>Indefinite</p> <p>Indefinite</p>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from April 1 19 70 to April 1 19 70 that (2) (we) last saw the deceased alive on April 1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rolando A. Mendoza		23B. DATE SIGNED 4-1-70			
23C. PHYSICIAN'S NAME (Type) ROLANDO A. MENDOZA, M.D.		23D. ADDRESS 100 N. Broadway, Baltimore, MD. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 4/2/70		24C. NAME of CEMETERY or CREMATORY LAURENCE CEM.	
24D. LOCATION LAURENCE MASS		25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR John F. Taylor, M.D.	
25C. FUNERAL DIRECTOR Connelly Funeral Home		ADDRESS 300		MACE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 3652	
T-460 BIRTH NO. 70 3652		1. NAME OF DECEASED (Type or Print) ROBERT B. TAYLOR		2. DATE AND HOUR OF DEATH 4.3.70 8.45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME AND HOSPITAL. 100 N. BROADWAY, BALTIMORE, MD.				A. STATE MD. B. COUNTY BALTIMORE 5300			
				C. CITY OR TOWN ESSEX		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 6 BLINKER COURT 21220			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/5/1909	9. AGE (In years last birthday) 60	11. Under 1 Yr. Months: Days: Hours: Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Leath Taylor.				14. MOTHER'S MAIDEN NAME Unknown Alice Russell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK				16. SOCIAL SECURITY NO. 228-01-9577		17. INFORMANT MARION TAYLOR	
				ADDRESS ABOVE			
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic Cardio Vascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Renal failure.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/14 19 70 to 4/3 19 70 that (I) (we) last saw the deceased alive on 4/3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jose Martinez				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/13/70	
23C. PHYSICIAN'S NAME (Type) Jose MARTINEZ				23D. ADDRESS Medical Out Building 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 4/6/70		24C. NAME OF CEMETERY or CREMATORY PATRICK MEM.		24D. LOCATION (City, town, or county) (State) STUART VA.	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR R. E. Jaber, M.D.		25C. FUNERAL DIRECTOR Connolly Funeral Home		ADDRESS 300 Mace	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-525		70 3653		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3653	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) FENHAGEN, GEORGE H.			
2. DATE AND HOUR OF DEATH 4-5-70 5:12 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 43 SO. BALTO. GEN. HOSP.		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2402		5. CITY OR TOWN BALTO	
6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7. STREET AND NUMBER 1440 HENRY ST. 21230		8. DATE OF BIRTH 11-16-87		9. AGE (in years last birthday) 82	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator-Grain		10B. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME JOHN (DEC)				14. MOTHER'S MAIDEN NAME Mollie? (DEC)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-6128-A		17. INFORMANT Family		ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE RESPIRATORY ARREST MINS. DUE TO, OR AS A CONSEQUENCE OF: (B) LEFT incarcerated inguinal DUE TO, OR AS A CONSEQUENCE OF: indirect Hernia (C) ASCVD			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3/18 1970 to 4/5 1970 that (I) (we) last saw the deceased alive on 5:12 PM 4/5 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Dhanbir S. Saluja	
23B. PHYSICIAN'S NAME (Type)		23C. ADDRESS SOUTH BALTO. GEN. HOSPITAL		23D. DATE SIGNED 4/5/70		23E. ATTENDING PHYSICIAN Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4 8 70		24C. NAME of CEMETERY or CREMATORY Glen Haven		24D. LOCATION Glen Burnie, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Robert E. Saluja		25C. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Fort Ave.	

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BIRTH NO.		70 3654		BALTIMORE CITY HEALTH DEPARTMENT		X		70 3654	
1. NAME OF DECEASED (Type or Print) S. CLARENCE WADE				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 4 5 1970 4:30 PM		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTO. C. CITY OR TOWN Catonsville D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
9. DATE OF BIRTH 8/27/1927		10. AGE (In years last birthday) 42		11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 104 Winters Lane			
11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MOSES WADE					
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		14B. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOLS		15. MOTHER'S MAIDEN NAME JOHNNA HILL					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES 1-1-46-1-26-47		17. SOCIAL SECURITY NO. 214-22-0729		18. INFORMANT ADDRESS MOLLIE THORNTON 1942 LAURETTA AT					
19. E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of torso DUE TO OR AS A CONSEQUENCE OF (abdomen & chest) (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 500 blk. of N. Mount St. 1603					
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 2-28-70 9:13 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subj. shot during assault and robbery by unknown assailant.					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.						DATE SIGNED 4-6-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/9/70		24C. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL		24D. LOCATION (City, town, or county) (State) BALTO MD			
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Marshall P. Hays		25D. ADDRESS 635 Guilmore St			

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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3655

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James O. Hall		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 9 S. Arlington Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 4 70 8:25 a.m.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1803	
9. DATE OF BIRTH 10/31/1914		10. AGE (In years lost birthday) 55	
11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNOWN R. HALL		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
15. MOTHER'S MAIDEN NAME AGNES HAWKINS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS ROBERTA BROOKS 2533 SHIRLEY AVE	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 412.4 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 4/4/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-8-70	
24C. NAME of CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT APR 7 1970		25B. NAME OF REGISTRAR Robert E. Spitz, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 3656					X REG. NO. 70 3656				
BIRTH NO. S-400					1. NAME OF DECEASED (Type or Print) Ray Owens Sell				
2. DATE AND HOUR OF DEATH Apr. 5, 1970 8:40 P M.					3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Parkway					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.				
C. CITY OR TOWN Baltimore					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER 2500 Wentworth Rd.									
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7 / 07	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Petty officer 1/c retired			10B. KIND OF BUSINESS OR INDUSTRY USN		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Chester Arthur Sell					14. MOTHER'S MAIDEN NAME Ella R. Pugh				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN 1942-1945 1947-1967			16. SOCIAL SECURITY NO. 578-01-7405		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.				
18. CAUSE OF DEATH I 412.3 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocardial Infarct, old II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs				
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Apr. 5 1970 to Apr. 5 1970 , that (I) (we) last saw the deceased alive on Apr. 5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. Roger Little, MD					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/6/70		
23C. PHYSICIAN'S NAME (Type) Raymond R. Little, SA Surg (R)					23D. ADDRESS US PHS Hospital, Balto, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/8/70		24C. NAME of CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Balto Co Md			
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970			25B. NAME OF REGISTRAR Robert E. Juby, MD		25C. FUNERAL DIRECTOR ADDRESS C.F. EVANS & SON 8802 Harford Rd				

July 8 1877. To the Hon. Secy. of the Interior

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

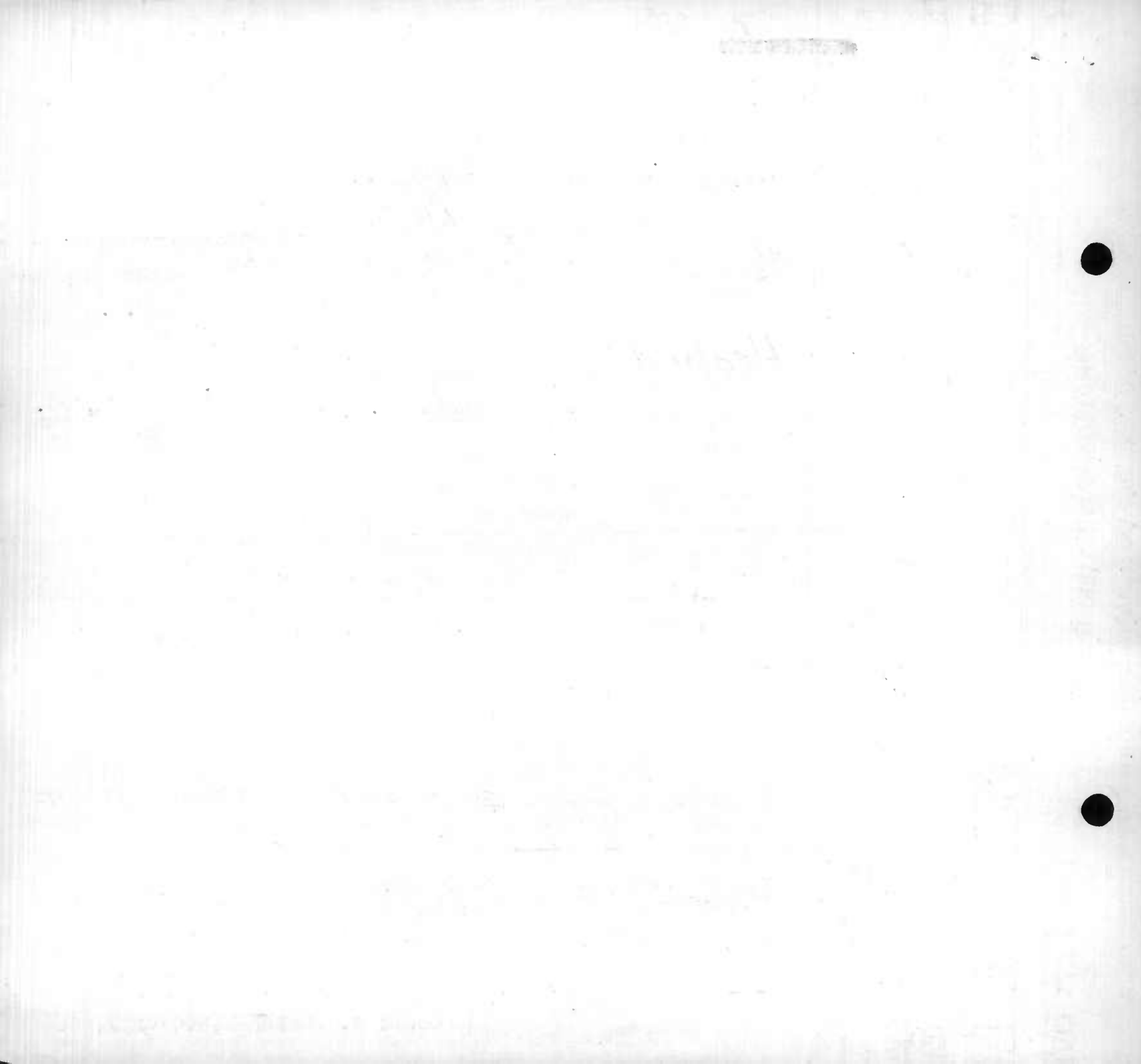
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 3657</u>	
BIRTH NO. <u>P-230 70 3657</u>				1. NAME OF DECEASED (Type or Print) <u>ELLA H. PICCIOTTO</u>		2. DATE AND HOUR OF DEATH <u>4/2/70</u> <u>745 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>MERCY HOSP.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2749</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MERCY HOSP.</u>				C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1636 Heathfield Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02/23/14</u>		9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>WETZERS</u>		11. BIRTHPLACE (State or foreign country) <u>Baltim. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>Giuseppe Sironi</u>				14. MOTHER'S MAIDEN NAME <u>Nancy ? FLORINZANI</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>216-03-2507</u>		17. INFORMANT <u>MR. FRANK J. PICCIOTTO, SR.</u> ADDRESS <u>SAME</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory Failure +</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Emphysema</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Diffuse Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10-20 days</u>	
				(B) <u>Metastatic Ca Both Lungs</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Undetermined</u>		<u>30 days</u>	
				(C) <u>Epithelial Ca origin</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Undetermined</u>		<u>90 days</u>	
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>yes</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>yes</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>yes</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 20</u> 19 <u>70</u> to <u>4/2</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/1</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Wm. B. REVER JR. M.D.</u>				23B. DATE SIGNED <u>4/2/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Wm. B. REVER JR. M.D.</u>	
23D. ADDRESS <u>801 Providence Rd. Towson, Md.</u>				23E. FUNERAL DIRECTOR <u>J. Walter Contelino</u> ADDRESS <u>5444 BELAIR Rd.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-6-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MOST HOLY REDEEMER</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>W. E. Taylor, Jr.</u>		25C. NAME OF REGISTRAR <u>W. E. Taylor, Jr.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 3658	
H-453 70 3658				BIRTH NO. [REDACTED]			
1. NAME OF DECEASED (Type or Print) <u>Ruth Healand</u>				2. DATE AND HOUR OF DEATH <u>3-31-70 8:23 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Montgomery</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 Johns Hopkins Hospital</u>				C. CITY OR TOWN <u>Gaithersburg</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>Rte 3</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-58</u>	9. AGE (In years lost birthday) <u>12</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas Healand</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Bladen</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Thomas R. Healand Gaithersburg, Md.</u>			
18. <u>746.61</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Congenital Heart Disease P.S., T.I.</u>		CAUSE OF DEATH <u>Myocardial Infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hemorrhagic Shock</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Operative Procedure</u> (C) <u>Cardiac Operative Procedure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>yrs.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>3/31/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CONG. HEART DISEASE PS</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/31/70 6:30 AM</u> to <u>8:23 AM</u> <u>3/31</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>31 MARCH</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.							
23A. SIGNATURE <u>Arthur Jenny II MD</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>3/31/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Arthur Jenny,</u>				23D. ADDRESS <u>M.D. The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-3-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Forest Oak Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Gaithersburg, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, ROCKVILLE, MC.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3659	
BIRTH NO. C-452		70 3659	
1. NAME OF DECEASED (Type or Print) MILTON C. COLLINS		2. DATE AND HOUR OF DEATH 4/5/70 10³⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION South Balti General 43		A. STATE Maryland B. COUNTY Anne Arundle C. CITY OR TOWN Glenn Burnie D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 430 Rogers Ave	
5. SEX M	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-02
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown (ELECTRICIAN) Retired		11. BIRTHPLACE (State or foreign country) USA, MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Fredrick Collins		14. MOTHER'S MAIDEN NAME Margaret (?)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-16-2566	17. INFORMANT MRS SALLY R. W. WOOD Friend 430 ROGERS AVE GLENN BURNIE
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) Cancer of the Lung	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 2 widespread metastasis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS HRS MONTHS	
19A. DATE OF OPERATION 1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-18 19 70 to 4-5 19 70 that (I) (we) last saw the deceased alive on 4-5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Arnold M. Wood, MD		23B. DATE SIGNED 4-6-70	
23C. PHYSICIAN'S NAME (Type) DONALD M. WOOD MD		23D. ADDRESS South Balti. Gen.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/8/70	24C. NAME of CEMETERY or CREMATORY BALTIMORE	24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR John E. Jones, R.D.	25C. FUNERAL DIRECTOR Henry Sanders & Sons Inc. ADDRESS Baltic Md

NOT ME CASE

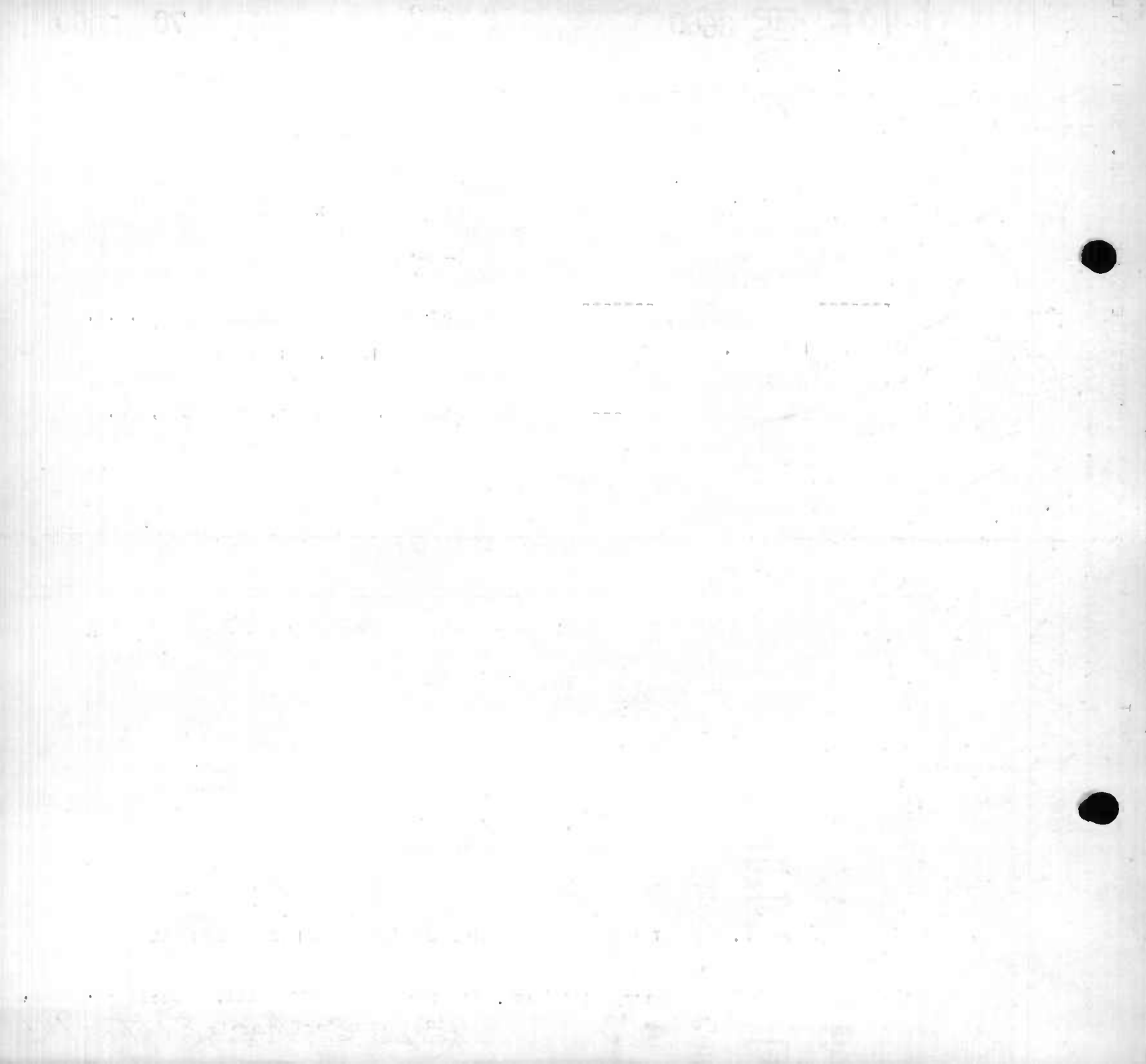
NOT

DR. SPRINGGATE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-400 70 3660		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3660	
BIRTH NO. <i>Cecil Co. Md.</i>				2. DATE AND HOUR OF DEATH <i>4/1/70 3:45 P.M.</i>			
1. NAME OF DECEASED (Type or Print) <i>DILL, CARL</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> 8. COUNTY <i>5700</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				C. CITY OR TOWN <i>ELKTON</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>JOHNS HOPKINS HOSPITAL 3601 N. BROADWAY BALTIMORE MD. 21205</i>				E. STREET AND NUMBER <i>RD # 1 Box 318</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-2-67</i>	9. AGE (In years last birthday) <i>3</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>JAMES DILL SR.</i>				14. MOTHER'S MAIDEN NAME <i>DORIS E. KENNARD</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT ADDRESS <i>James F. Dill, Sr. Elkton, Md.</i>	
18. <i>746.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Cadaveric arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Pathology of Fallot</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i> <i>3 1/2 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>attempted surgical correction 4/1/70</i>							
19A. DATE OF OPERATION <i>4-1-70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Pathology of Fallot</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/31 1970</i> to <i>4/1 1970</i> , that (I) (we) last saw the deceased alive on <i>3:45 PM 4/1 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (<u>did</u>) (<u>did not</u>) view the body after death.							
23A. SIGNATURE <i>Todd T. Grant, MD</i>				23B. DATE SIGNED <i>4-1-70.</i>		23C. PHYSICIAN'S NAME (Type) <i>TODD T. GRANT</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>4/4/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cherry Hill Meth. Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Cherry Hill, Cecil Co. Md.</i>				24E. FUNERAL DIRECTOR <i>Hicks Home for Funerals</i>		24F. ADDRESS <i>Ralph E. Hicks, Elkton, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 7 1970</i>				25B. NAME OF REGISTRAR <i>Walter E. ...</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3661	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) LEWIS, JAMES H.		2. DATE AND HOUR OF DEATH 4/4/70 3:10 pm			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 2002 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2566 W. Fairmount Ave.			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-97		9. AGE (In years lost birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Newark, New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Louis Lewis			
14. MOTHER'S MAIDEN NAME Josephine Lewis		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/16/16 3/8/1919			
16. SOCIAL SECURITY NO. 212-14-0933-A		17. INFORMANT Elsie Lewis (wife) ADDRESS same as above			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Malignant exchlexie DUE TO, OR AS A CONSEQUENCE OF: (B) Tumor of Colon DUE TO, OR AS A CONSEQUENCE OF: (C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) X	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/12/70 19 70 to 4/4 19 70 , that (I) (we) last saw the deceased alive on 3:10 pm 4/4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. Bose M.D.				23B. DATE SIGNED 4/4/70	
23C. PHYSICIAN'S NAME (Type) PRATIMA BOSE M.D.				23D. ADDRESS Lutheran Hospital, Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-7-70		24C. NAME OF CEMETERY or CREMATORY Balto Nat'l Cem.	
24D. LOCATION (City, town, or county) (State) Balto, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 7 1970			
25B. NAME OF REGISTRAR J. E. Sabin, M.D.		25C. FUNERAL DIRECTOR Morton E. Dgett F.H. ADDRESS 1701 Laurels St			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

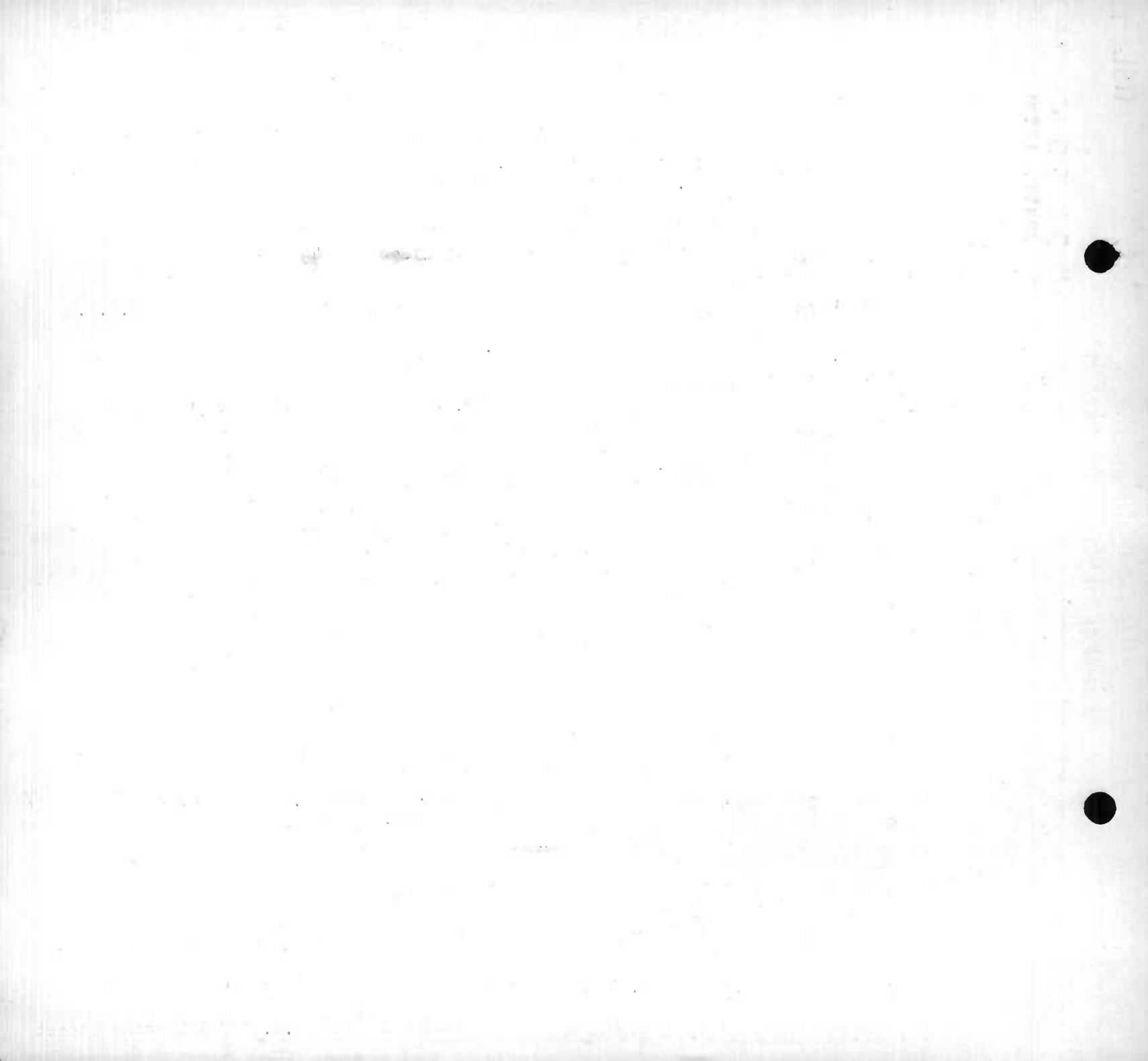
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3662</u>	
BIRTH NO. <u>67-0750470 3662</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Goodman Kevin Wade</u>			2. DATE AND HOUR OF DEATH <u>4/3/70 at 7:15 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital of Maryland</u> <u>730 Ashburton St. Baltimore</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1608</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>City</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>			6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>4-17-67</u>
13. FATHER'S NAME <u>Hoover Goodman, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Phyllis Goodman</u>		9. AGE (In years lost birthday) <u>2 yrs</u>
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <u>NO.</u>			16. SOCIAL SECURITY NO. <u>-0-</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>
17. INFORMANT <u>M. A. Gheewala Lutheran Hospital.</u>			12. CITIZEN OF WHAT COUNTRY? <u>States</u>		
18. <u>5-08.4</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Laryngeal Edema, Septic Pneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Retropharyngeal & Retro-oropharyngeal Abscess.</u> (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>4-3-70</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? <input checked="" type="checkbox"/> Yes or No <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>No</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>			21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>
22. I certify that (I) (this hospital) attended the deceased from <u>2:45 PM on 4-3-1970</u> to <u>7:15 PM on 4-3-1970</u> that (I) (we) last saw the deceased alive on <u>4-3-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. A. Gheewala</u>			23B. DATE SIGNED <u>4/3/70</u>		23C. PHYSICIAN'S NAME (Type) <u>M. A. Gheewala.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4/7/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Western Star Cem.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Morton E. Dyett F.H.</u>
24D. LOCATION <u>Catonsville, Md</u>			25D. ADDRESS <u>1701 Laurens St.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

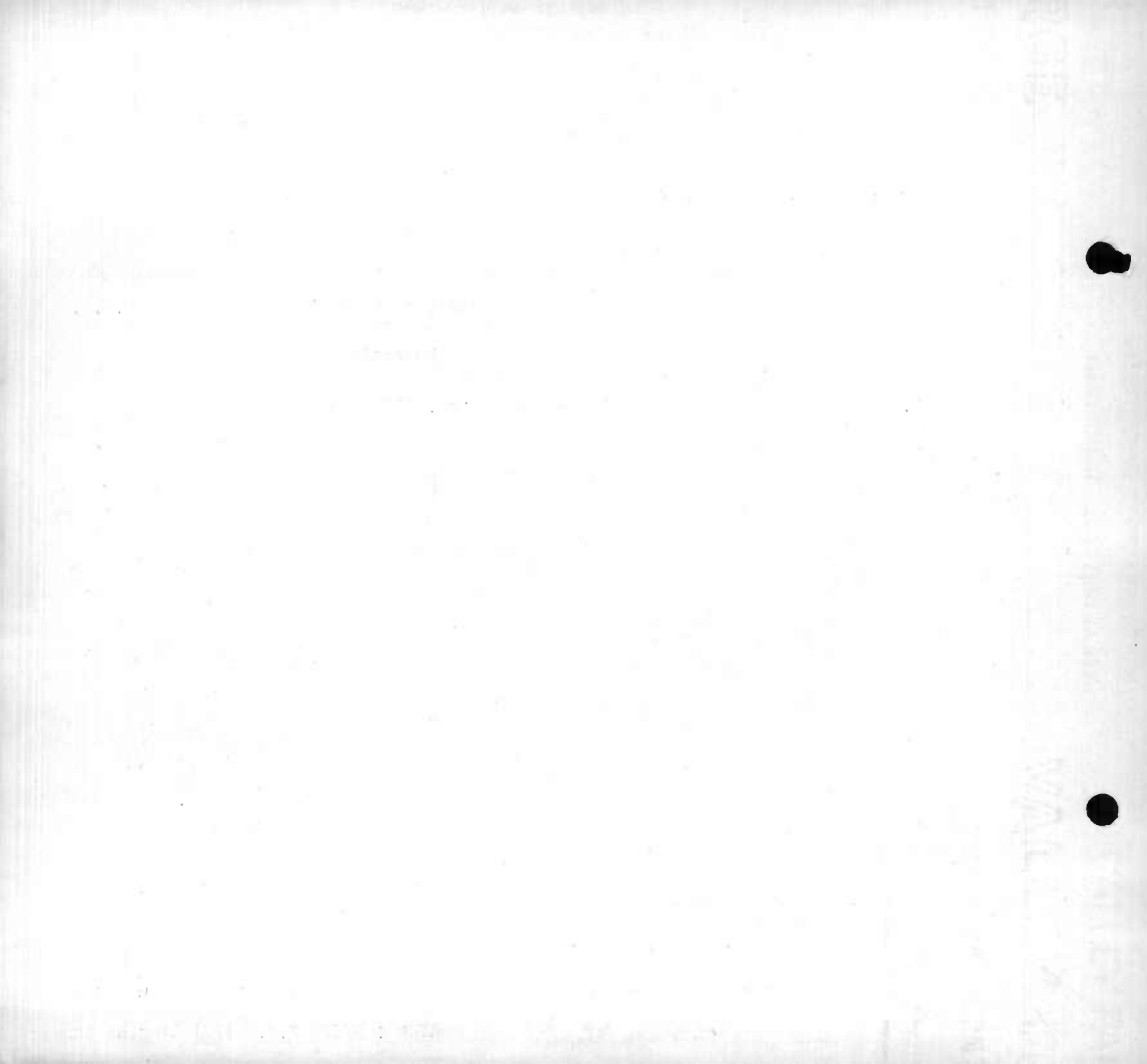
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
70 3663		70 3663		X
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Irene Jones		4/3/70 6 ¹⁰ P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital		A. STATE		B. COUNTY
		MARYLAND		BALTIMORE
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER		112 VIRGINIA AVE		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
FEMALE	NEGRO	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-22-1920	49
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Domestic Work				Baltimore, Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
N/A		N/A		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
No.			Mr. Jonas Jones 1521 Stonewood Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		Respiratory Failure		
		(B) Metastatic Breast Ca. DUE TO, OR AS A CONSEQUENCE OF:		
		(C) ? Pul. Embolus		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		pneumonia, CHF		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (this hospital) attended the deceased from 3/4/70 19 70 to 3/4/70 19 70, that (we) last saw the deceased alive on 3/4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Ralph De Franco		4/3/70		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Ralph De Franco M.D.		Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)	
Burial	4-7-70	St. Luke Cemetery	Reisterstown, Maryland	
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS		
APR 7 1970	Robert E. Taylor, M.D.	MORTON E. DYETT F.H. 1701 Laurens Street		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO.		70 3664	
BIRTH NO.		70 3664		CERIFICATE OF DEATH		X REG. NO. 70 3664	
1. NAME OF DECEASED (Type or Print) <i>Scott, John H.</i>				2. DATE AND HOUR OF DEATH <i>4-6-70</i> <i>5:40 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 The Johns Hopkins Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>14 South Lane</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/27/1867</i>	9. AGE (In years last birthday) <i>102</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Jericho, South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Jacob Scott</i>			14. MOTHER'S MAIDEN NAME <i>Lucretia Scott</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>			16. SOCIAL SECURITY NO. <i>153-42-5346</i>		17. INFORMANT <i>Mrs. Elizabeth Day</i>		
						ADDRESS <i>14 South Lane</i>	
18. <i>185-X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>metastatic carcinoma of the prostate</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>several years duration</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>4/2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4/2</i> 19 <i>70</i> to <i>4/6</i> , <i>5:40 AM</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>4/5</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Harry S Pond M.D.</i>				23B. DATE SIGNED <i>4/6/70</i>			
23C. PHYSICIAN'S NAME (Type) <i>HA Harry S. Pond, M.D.</i>				23D. ADDRESS <i>Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-9-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Atlantic City Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Pleasantville, New Jersey</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 7 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>MORTON & DYETT F.H. 1701 Laurens Street</i>			



FUNERAL DIRECTOR: IMPORTANT

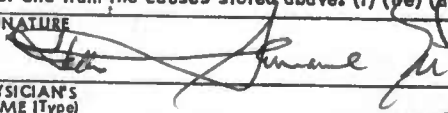
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 3665		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3665	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Gloria L Hill</i>		2. DATE AND HOUR OF DEATH <i>4/3/70</i> <i>5:00</i> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>1608</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>39 Provident Hospital</i>		E. STREET AND NUMBER <i>611 Woodington Rd</i>			
5. SEX <i>F</i>	6. RACE <i>N N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-30-46</i>	9. AGE (in years last birthday) <i>24</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Soc. Sec.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Eddie Hill</i>		14. MOTHER'S MAIDEN NAME <i>Lucille Hill</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-48-6039</i>		17. INFORMANT <i>Mrs. Lucille Hill</i>	
18. <i>5-60-41</i>		CAUSE OF DEATH		ADDRESS <i>611 Woodington Rd</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Septicemia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>72 hrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>intraabdominal abscess</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>5 days</i>	
(C) <i>suspected intraabdominal perforation</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Intestinal obstruction 20 adhesions</i>			
19A. DATE OF OPERATION <i>4/3/70</i>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>intestinal obstruction</i>	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4/1/70</i> to <i>4/3/70</i> that (I) (we) last saw the deceased alive on <i>4/3/70</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edward O. Hunt, Jr.</i>		23B. DATE SIGNED <i>4/3/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Edward O. Hunt, Jr. M.D.</i>	
23D. ADDRESS <i>Provident Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>4-8-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 7 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>Horton E. Dyett F.H.</i>	
				ADDRESS <i>1701 Laurens St.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

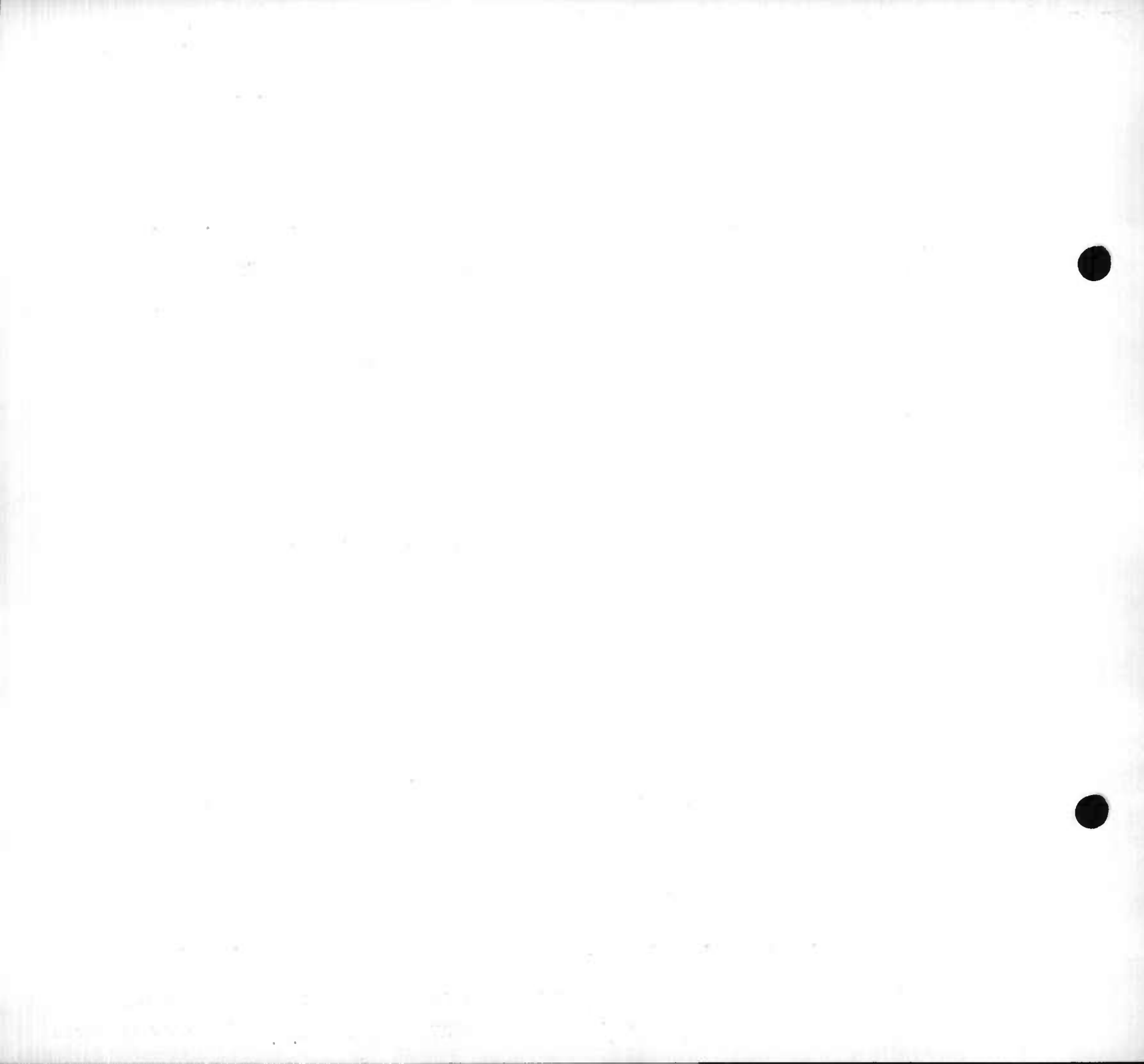
BALTIMORE CITY HEALTH DEPARTMENT				70 3666		REG. NO. 70 3666	
BIRTH NO.				70 3666		70 3666	
1. NAME OF DECEASED (Type or Print) ANNIE WOODRUM				2. DATE AND HOUR OF DEATH 4-4-70 10:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION LINCOLN MEMORIAL NURSING HOME IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 27 N. CAREY STREET				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN BALTO. MD. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1531 E. Preston St.			
5. SEX F	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/99	9. AGE (in years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN (Rose Bell)				14. MOTHER'S MAIDEN NAME UNKNOWN (Anthony Bell)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr John Woodrum 1531 E Preston St			
18. 4/10/70 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 4		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-19- 19 70 to 4-4- 19 70 that (I) (we) last saw the deceased alive on 4-4- 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED 4-4-70		23C. PHYSICIAN'S NAME (Type) DR. ROBERT E. TAYLOR	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-7-70		24C. NAME OF CEMETERY OR CREMATORY Nottaway Bapt Ch Cem Crewe Va		24D. LOCATION (City, town, or county) (State) Crewe Virginia	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mr. J. H. Taylor		25D. ADDRESS Mr. J. H. Taylor F.H. Balto - Md 21111	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3667</u>	
BIRTH NO. <u>70 3667</u>		1. NAME OF DECEASED (Type or Print) <u>Lillie Adams</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>1:25 p.m.</u> <u>4-2-70</u> M.			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>605</u>			
5. SEX <u>Female</u> 6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-13-95</u> 9. AGE (In years last birthday) <u>75</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland, Baltimore</u>	
13. FATHER'S NAME <u>James Burris</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Burris</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH Records:</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>	
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>3 weeks</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>cardiovascular accident</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>3-4</u> 19 <u>70</u> to <u>4-2</u> 19 <u>70</u> that (H) (we) last saw the deceased alive on <u>4-2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John R. Brechtel, M.D.</u>				23B. DATE SIGNED <u>4-2-70</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>Baltimore City Hospital</u> <u>4940 Eastern Ave., Balto., Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-7-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTON & DYETT F.H.</u>			
25D. ADDRESS <u>1701 Laurens Street</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 3668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 70 3668

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MARY H. BROWN</u>		2. DATE AND HOUR OF DEATH <u>4-4-70</u> <u>6:30 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON Secours Hospital</u> <u>3420 25 W. Fayette St.</u> <u>Baltimore Md 21223</u>				A. STATE <u>Maryland</u> B. COUNTY <u>1604</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1919 Lauretta Ave 21223</u>					
5. SEX <u>F</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-1-26</u>	9. AGE (In years last birthday) <u>44</u>	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Girl</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bickford Rest.</u>		11. BIRTHPLACE (State or foreign country) <u>Hocksville, N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Cordy Crawford</u>			14. MOTHER'S MAIDEN NAME <u>Zelphia Crawford</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>218-22-2261</u>		17. INFORMANT <u>Mrs. Barbara Crawford</u>	
		ADDRESS <u>4903 Queensbury Ave</u>			
18. <u>4-27-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>2 hrs</u> <u>pulmonary edema</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>4/4</u> 19 <u>70</u> to <u>4/4</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>4/4</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Wm E. Beaver MD</u>				23B. DATE SIGNED <u>4/4/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Wm E. Beaver</u>				23D. ADDRESS <u>1701 Lauretta St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/9/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>National (Balt.) Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balt.</u> <u>Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton's Dyett F.H.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3669</u>	
BIRTH NO. <u>70 3669</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WILLIE WILLIAMS</u>			2. DATE AND HOUR OF DEATH <u>4/4/70</u> <u>10 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>12 SINAI HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1304</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u>			C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>10/15/96</u>		9. AGE (In years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Calvert Co., South Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Willie Williams</u>		
14. MOTHER'S MAIDEN NAME <u>Janie Williams</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		
16. SOCIAL SECURITY NO. <u>612-03-0362</u>			17. INFORMANT <u>Mrs. Irene Cosby</u>		
18. <u>4/3/70</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular Accident</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertension</u>			(B) <u>Arteriosclerotic cardiovascular disease</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>4/3/70</u> 19 to <u>4/4/70</u> 19 that (1) (we) last saw the deceased alive on <u>4/4/70</u> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D. Graynor MD</u>			23B. DATE SIGNED <u>4/4/70</u>		23C. PHYSICIAN'S NAME (Type) <u>GRAYNOR</u>
23D. ADDRESS <u>Sinai Hospital</u>			23E. DEGREE <u>MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/9/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION <u>Balto.</u>		24E. (City, town, or county)		24F. (State) <u>MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Horton & Dyett F.H.</u>	
25D. ADDRESS <u>1701 Laurens St.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

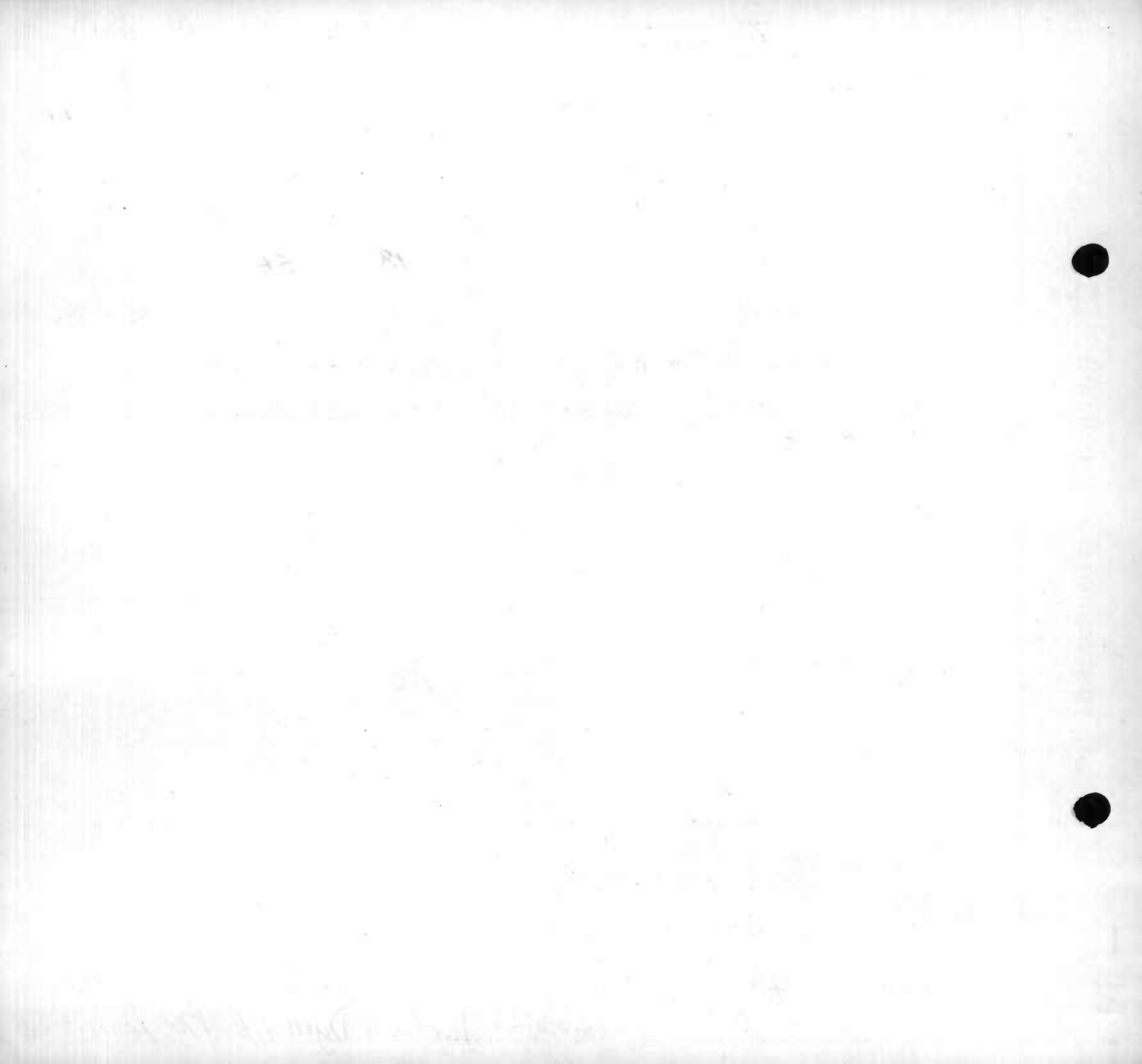
BIRTH NO.		70 3670		BALTIMORE CITY HEALTH DEPARTMENT		70 3670	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print)		James Barney (Barney)		2. DATE AND HOUR OF DEATH		March 31, 1970 9:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Provident Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 1017 Carroll Ave			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hosp (D.O.A.)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1017 Carroll Ave							
5. SEX M	6. RACE Unknown	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-8-1894	9. AGE (in years lost birthday) 75	11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Co. Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.A				13. FATHER'S NAME Unknown			
14. MOTHER'S MAIDEN NAME Unknown				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Medical Examiner			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF: Coronary Occlusion			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Urinary retention			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/1/70 to 4/3/70 that (I) (we) last saw the deceased alive on March 23, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George McDonald				23B. DATE SIGNED 4/3/70			
23C. PHYSICIAN'S NAME (Type) Dr. George McDonald				23D. ADDRESS 844 N Carey Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/7/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR E. Barber, R.D.		25C. FUNERAL DIRECTOR Morton E. Dyett F.H. 1701 Laurens St.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3671				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3671			
1. NAME OF DECEASED (Type or Print) Woodcuff Crowder Flora				2. DATE AND HOUR OF DEATH 4-3-70 2:20 P. M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hosp. of Md. 46				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1511							
5. SEX F		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-7-13		9. AGE (In years lost birthday) 56		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Gaffney, South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Callahan				14. MOTHER'S MAIDEN NAME Mary Jane Callahan							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.				16. SOCIAL SECURITY NO. 220-30-1779		17. INFORMANT Mrs. Viola Epps				ADDRESS 1503 N. Decker Ave	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary edema (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION No operation				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No operation				20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No injury				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No injury			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) No injury				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? No injury			
22. I certify that (I) (this hospital) attended the deceased from 4-3-1970 to 4-3-1970, that (I) (we) lost saw the deceased alive on 4-3-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Behnaz Jalali				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 4-3-70			
23C. PHYSICIAN'S NAME (Type) B. Jalali M.D.				23D. ADDRESS Lutheran Hosp. of Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/8/70		24C. NAME of CEMETERY or CREMATORY Arlington Mem. Park		24D. LOCATION Baltimore		(City, town, or county) (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR Morton E. Dyett, F.H.			
								ADDRESS 1701 Laurens St			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO. 69-13870

1. NAME OF DECEASED (Type or Print) CHRISTINE LOGAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 4 2 70 3:54 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour April 2, 1970 3:54 p.m.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1606	
9. DATE OF BIRTH 8-4-1969		10. AGE (In years lost birthday) 7	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		13. FATHER'S NAME Walter Ellis	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		15. MOTHER'S MAIDEN NAME Ruth Logan	
17. SOCIAL SECURITY NO. -0-		18. INFORMANT ADDRESS Mr. Walter Ellis 99 Russell Street	
19. 480X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Bilateral bronchopneumonitis, viral (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/3/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-8-70	
24C. NAME OF CEMETERY or CREMATORY Western Star Cemetery		24D. LOCATION (City, town, or county) (State) Catonsville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Robert E. Tabor, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	

Letter from M.E.'s office 5-25-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>70 3673</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3673 4</u>			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
Baby Girl Daniel, Gladys				4/1/70 4:48 P							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE				B. COUNTY			
31 BALTIMORE CITY HOSPITALS				Maryland				907			
4940 Eastern Avenue				C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
Baltimore, Maryland 21224				Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				2524 Robb Street 21218							
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4-1-70				1 32	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
								B.C.H.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Roosevelt Daniel				Gladys Hoyles				USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
								4940 Eastern Avenue			
								BCH-Records Baltimore, Maryland 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				(B) Prematurity DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2				Yes		Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from 4/1 1970 to 4/1 1970 that (I) (we) last saw the deceased alive on 4/1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
Jay W. Pettegrew, M.D.				4-1-70							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
Jay W. Pettegrew, M.D.				4940 Eastern Avenue							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
Cremated				4/2/70				Baltimore City Hospitals			
24D. LOCATION (City, town, or county) (State)				24E. DATE REC'D BY HEALTH DEPT.				24F. NAME OF REGISTRAR			
Baltimore, Maryland 21224				APR 7 1970				Robert E. Taylor, M.D.			
25A. FUNERAL DIRECTOR ADDRESS				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			

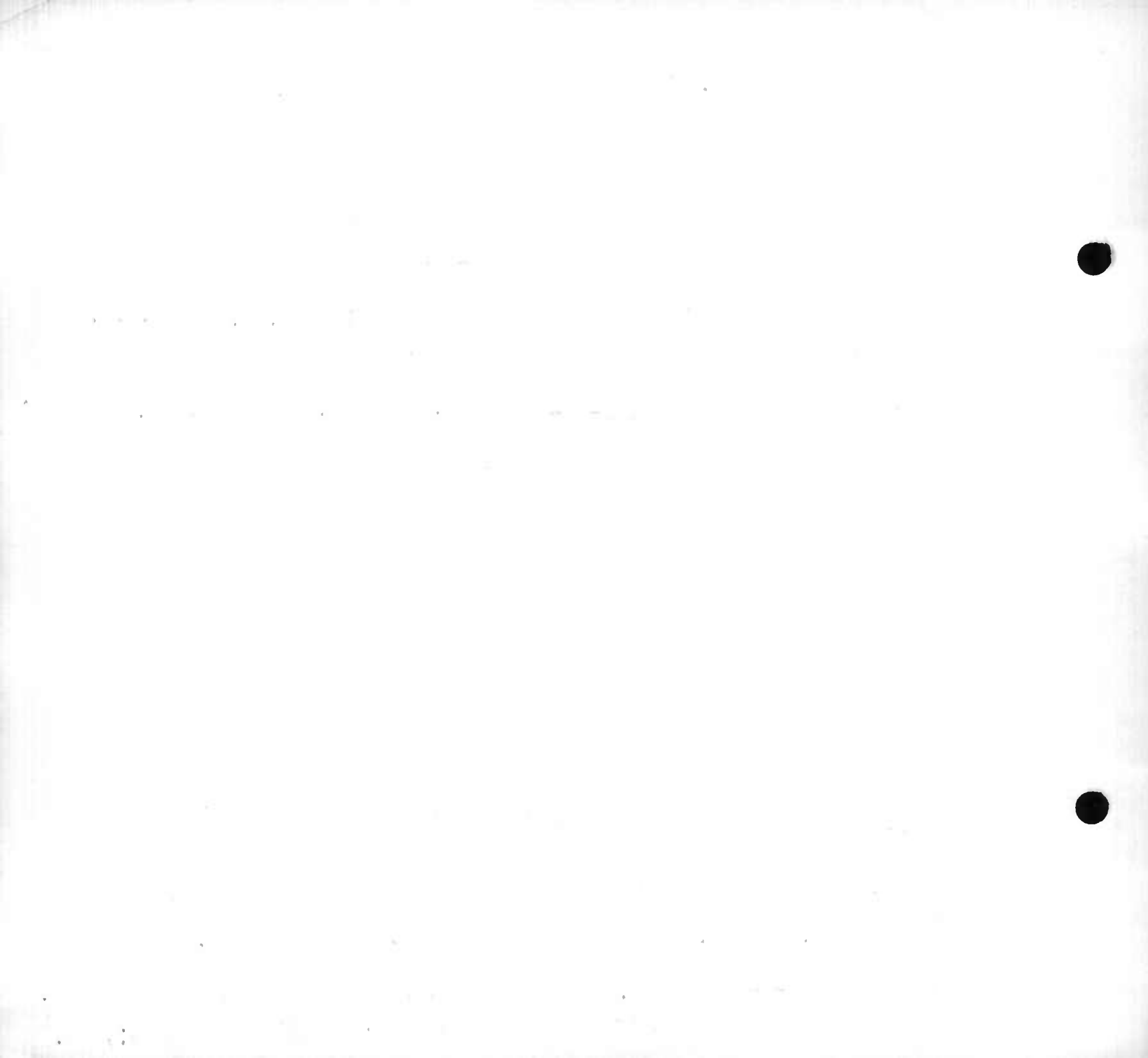
HOSPITAL DISPOSAL



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 3674
T-620 70 3674 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 1.2em;">Ruth S. Through</div>		2. DATE AND HOUR OF DEATH <div style="text-align: center; font-size: 1.2em;">April 2, 1970 9⁴⁵ P M.</div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="font-size: 1.5em;">00 106 Woodlawn Road</div>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2711 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <div style="font-size: 1.2em;">5104 Whiteford Avenue</div>		
5. SEX <div style="text-align: center; font-size: 1.2em;">F</div>	6. RACE <div style="text-align: center; font-size: 1.2em;">W</div>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <div style="font-size: 1.2em;">7-30-1877 92</div>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">Homemaker</div>		10B. KIND OF BUSINESS OR INDUSTRY <div style="font-size: 1.2em;">Own Home</div>		11. BIRTHPLACE (State or foreign country) <div style="font-size: 1.2em;">New York City N. Y.</div>
13. FATHER'S NAME <div style="font-size: 1.2em;">Francis Horatio Stubbs</div>		14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em;">Mary Eliz Burnett</div>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="text-align: center; font-size: 1.2em;">No</div>		16. SOCIAL SECURITY NO. <div style="font-size: 1.2em;">334-44-2734</div>		17. INFORMANT <div style="font-size: 1.2em;">Mrs. James O. Armacost, Jr.</div>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <div style="font-size: 1.2em;">412.4 I</div>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.5em;">Patent aortic cardiac vascular disease</div>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <div style="font-size: 1.2em;">0</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <div style="font-size: 1.2em;">No</div>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from July 1968 to April 1970 that (I) (we) last saw the deceased alive on 25 October 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <div style="font-size: 1.5em;">John W. Barnaby</div>				23B. DATE SIGNED <div style="font-size: 1.2em;">3 April 1970</div>
23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em;">Dr. John W. Barnaby</div>		23D. ADDRESS <div style="font-size: 1.2em;">1652 E. Belvedere Ave.</div>		
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em;">Burial</div>		24B. DATE <div style="font-size: 1.2em;">4-6-1970</div>		24C. NAME of CEMETERY or CREMATORY <div style="font-size: 1.2em;">St. John's Episcopal</div>
24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.2em;">Baltimore, Md.</div>		25A. DATE REC'D BY HEALTH DEPT. <div style="font-size: 1.2em;">APR 7 1970</div>		
25B. NAME OF REGISTRAR <div style="font-size: 1.2em;">Robert E. Sander, M.D.</div>		25C. FUNERAL DIRECTOR <div style="font-size: 1.2em;">Henry W. Jenkins & Sons Co.</div>		
25D. ADDRESS <div style="font-size: 1.2em;">4905 York Road Balto., Md.</div>		25E. ADDRESS <div style="font-size: 1.2em;">21212</div>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3675		REG. NO. 70 3675	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>G ENEVIEVE M. KENNEDY</u>				2. DATE AND HOUR OF DEATH <u>April 3, 1970</u> <u>4:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNION MEMORIAL HOSPITAL</u> <u>44</u>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MARYLAND - BALTIMORE</u> <u>2711</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4809 Crowson Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 6, 1879</u>	9. AGE (In years last birthday) <u>91</u>	If Under 1 Yr. Months: <u> </u> Days: <u> </u>	If Under 24 Hrs. Hours: <u> </u> Min: <u> </u>	10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(NONE) RETIRED</u>
10B. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>			
13. FATHER'S NAME <u>JAMES M. KENNEDY</u>				14. MOTHER'S MAIDEN NAME <u>MARY BIRT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>(UNKNOWN) NO</u>				16. SOCIAL SECURITY NO. <u>217-60-0299</u>		17. INFORMANT <u>ANITA O'BRIEN</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE - PNEUMONIA</u> CAUSE OF DEATH <u>(A) IMMEDIATE CAUSE</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4-3-70</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3-30</u> <u>1970</u> to <u>4-3</u> <u>1970</u> that (I) (we) last saw the deceased alive on <u>4-3</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-3-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>VICTOR C. GALLARDO</u>				23D. ADDRESS <u>M.D. UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/6/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>			
				ADDRESS <u>4905 York Rd. Balto., Md. 21212</u>			

1947-1948

1949-1950

1951-1952

FUNERAL DIRECTOR: IMPORTANT

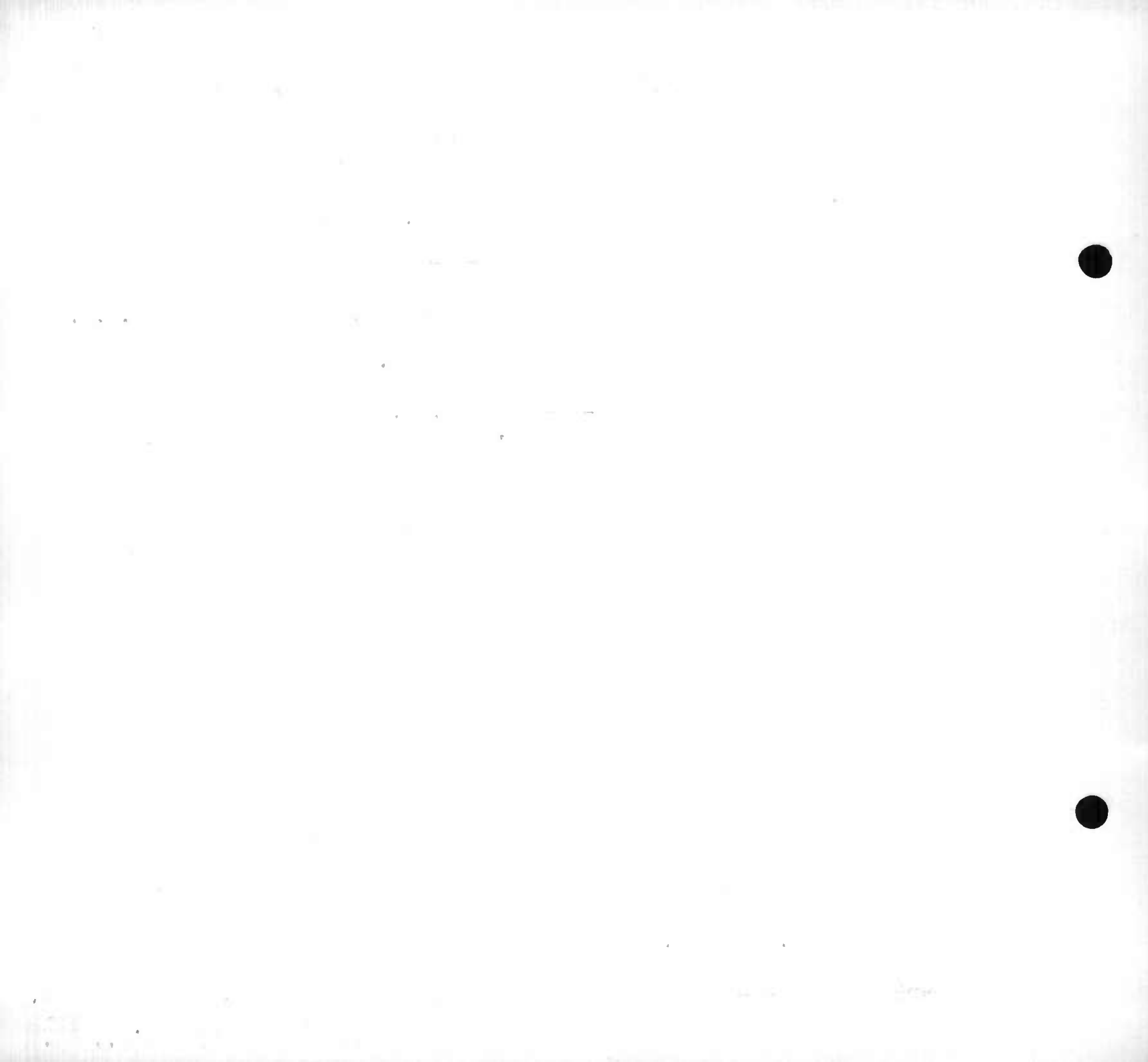
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3676	
<div style="display: flex; justify-content: space-between;"> D-520 70 3676 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Mildred H. Donaghy		April 4, 1970 7³⁰ A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
90 Long Green Nursing Home		Maryland		1201	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore 21210		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		Broadview Apts.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11/5/1895	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk-Freight Claims B & O RR				Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George Dopman		Margaret Collins		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		705-05-7412		Auston X. Dopman 1501 Dunlora Rd.	
18. 4124 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.)		Acute pulmonary Edema			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) As CVD			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 19 67 to Apr 4 19 70 that (I) (we) last saw the deceased alive on Apr 4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Dr. William G. Helfrich		4-6-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. William G. Helfrich		5006 Roland Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/7/70		Parkwood	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 7 1970		E. J. Barber, M.D.		H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	

116 W UNIVERSITY PKWY.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-534 70 3677		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3677	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Anne McLaughlin Pendleton		April 4, 1970 9:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE 8. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			Maryland		
217 E. Biddle Street			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			217 E. Biddle Street		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-27-1896	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		Own Home		Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Hugh McLaughlin		Mary E. Murphy		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-48-4967		Mr. E. Morgan Pendleton Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Renal disease chronic, etc. etc. undetermined		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			arteriosclerotic cardiovascular disease		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 4/4 19 69 to 4/4 19 70					
that (1) (we) last saw the deceased alive on 4/4 19 70 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
James R. Karns				4/6/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. James R. Karns				Medical Arts Building	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4-8-70		New Cathedral Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 7 1970		Robert E. Taylor, M.D.		Henry W. Jenkins & Sons Co. 21212 4905 York Road Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3678</u>
S-650 70 3678		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Virginia Heath Sauerwein</u>		2. DATE AND HOUR OF DEATH <u>April 4, 1970</u> <u>1:00 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>		A. STATE <u>Md.</u> B. COUNTY <u>12-01</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3900 N. Charles St.</u> <u>Apt. 1313</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>W</u>		E. STREET AND NUMBER <u>3900 N. Charles St.</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-14-1896</u>		9. AGE (In years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Heath</u>		
14. MOTHER'S MAIDEN NAME <u>Anna Bianca Whidmayer</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. E. Maxwell Sauerwein</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>492 X1</u> <u>Chronic Thrombosis</u> <u>Posterior Ischemic Stroke</u> <u>Acute Myocardial Infarction</u> <u>with</u> <u>marked atherosclerotic changes</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>15 min</u> <u>11 "</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR? <u>Deceased died in sleep</u> <u>Medical Director City Auditor's Office</u>		22. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 1970</u> to <u>Feb 19 1970</u> and that (I) (we) last saw the deceased alive on <u>Feb 19 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Dr. W. H. Woody</u>		23B. DATE SIGNED <u>4-7-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. W. H. Woody</u>
23D. ADDRESS <u>1403 Park Ave.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>4-7-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount Cemetery</u>		24D. LOCATION <u>Baltimore Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>
25D. ADDRESS <u>Baltimore Md. 21212</u>		25E. ADDRESS <u>4905 York Rd.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3679</u>
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Loretta F. Gannon</u>		2. DATE AND HOUR OF DEATH <u>April 6, 1970</u> <u>8⁰⁰ A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 4636 Kernwood Avenue</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____ C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4636 Kernwood Avenue</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-1886</u>	9. AGE (In years last birthday) <u>83</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Scranton, Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Dugan Rowley</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Flood</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		
16. SOCIAL SECURITY NO. <u>215-50-9583</u>		17. INFORMANT <u>Mr. Roland Gannon</u> ADDRESS <u>Same</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4124 I</u> CAUSE OF DEATH <u>Arteriosclerotic Cardio-Vascular Disease</u> (A) IMMEDIATE CAUSE <u>DUE TO, OR AS A CONSEQUENCE OF:</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 	
22. I certify that (I) (this hospital) attended the deceased from <u>January 1970</u> to <u>April 6, 1970</u> that (I) (we) last saw the deceased alive on <u>April 6, 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>William H. Fusting</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4-7-70</u>
23C. PHYSICIAN'S NAME (Type) <u>Dr. William H. Fusting</u>		23D. ADDRESS <u>4230 Loch Raven Blvd.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-8-70</u>	24C. NAME of CEMETERY or CREMATORY <u>Bethel Methodist Church</u>	24D. LOCATION (City, town, or county) (State) <u>Hurffville, N. J.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1970</u>		25B. NAME OF REGISTRAR <u>W. E. Jenkins, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> ADDRESS <u>21212 4905 York Road Balto., Md.</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
70 3680				70 3680	
K-536				70 3680	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Geneva D. Kinter		April 5, 1970 11:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		
90 Edgewood Nursing Home			Md.		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			3113 W. Belvedere Ave.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8-20-07	62	11 Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		Own Home		West Virginia	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Arch L. Williams			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			220-14-7673		Lawrence Kinter
					Same
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Cerebral arteriosclerosis 10 yr		
ANTECEDENT CAUSES			(B) Generalized arteriosclerosis 15 yr		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II			Terminal bronchopneumonia 3 days		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan 23 1970 to Apr 5 1970 that (I) (we) last saw the deceased alive on Apr 5 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Frederick J. Vollmer M.D.				Apr 6, 1970	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Frederick J. Vollmer M.D.		6100 York Road			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Rem. Burial		4/9/70		Mitchell Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 7 1970		Robert E. Taylor, M.D.		H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	

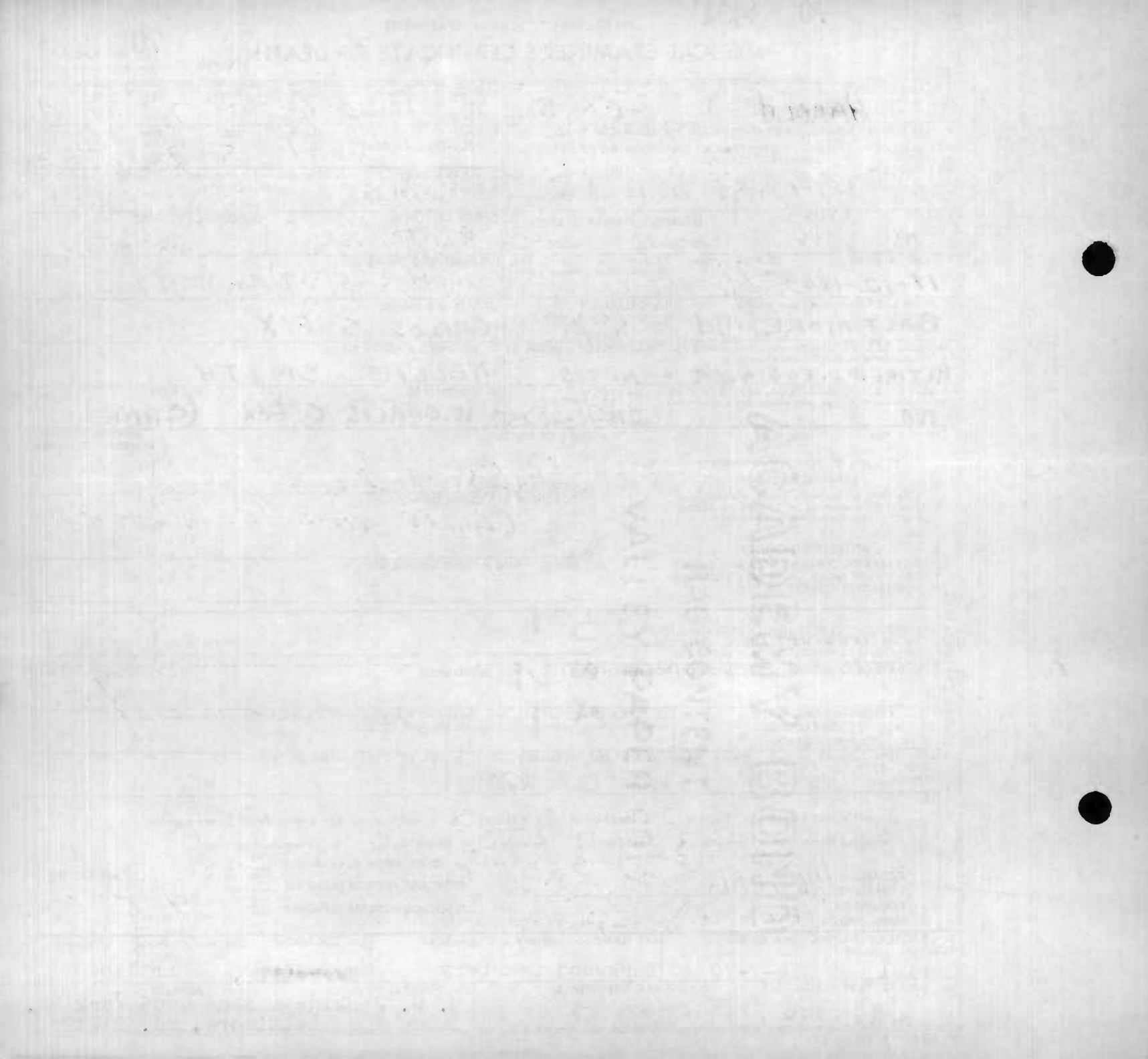


70 3681
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
70 3681

BIRTH NO.

REG. NO.

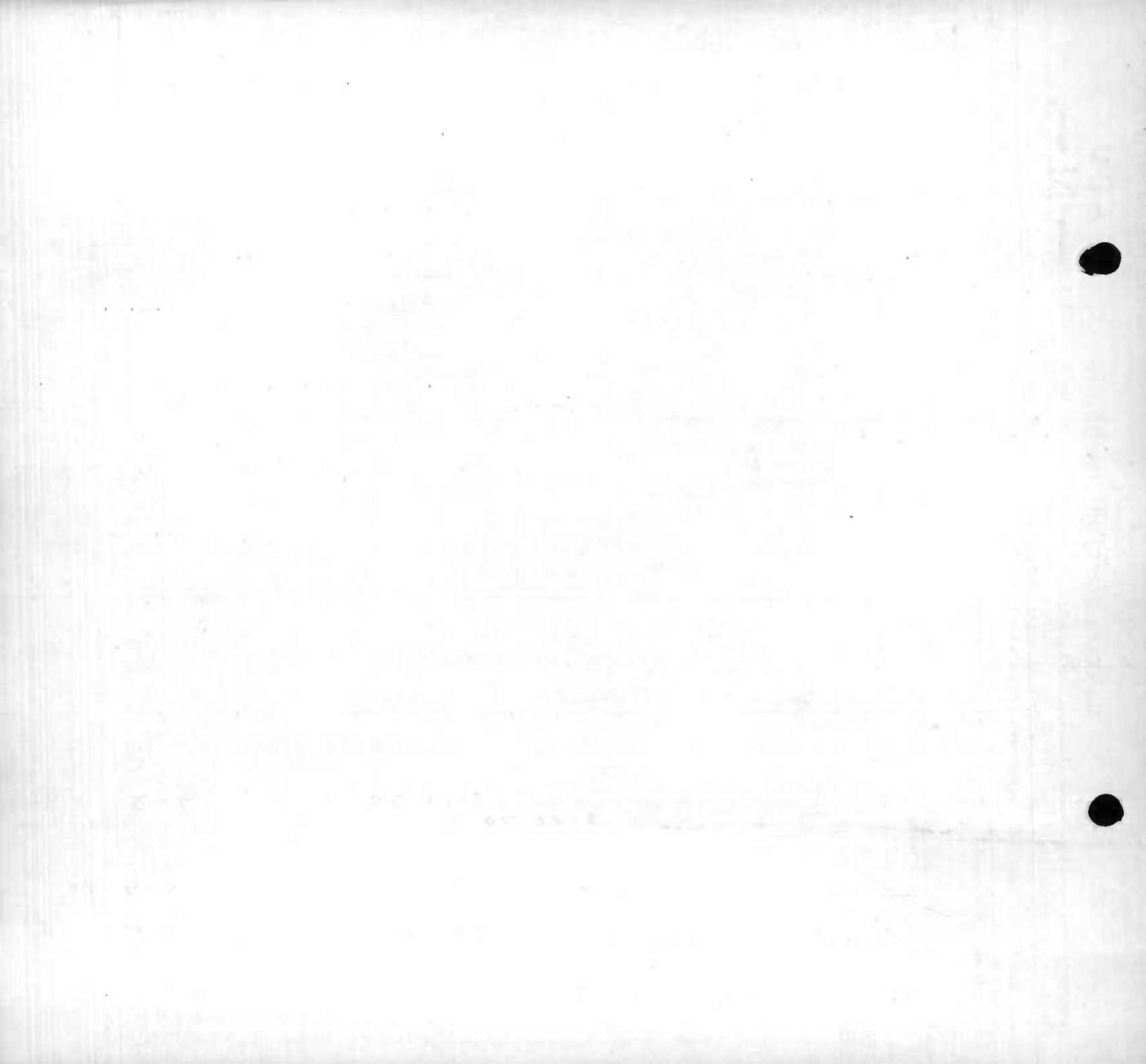
1. NAME OF DECEASED (Type or Print) HAROLD D. FOX, SR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> 4 5 70 230 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2943 St. Paul St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 5 70 230 A.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE MD B. COUNTY 1202		6. SEX M 7. RACE W 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 11-12-1883		10. AGE in years (last birthday) 86	
11. BIRTHPLACE (State or foreign country) BALTIMORE, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CARLOS S. FOX		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - ENGINEER - AUTOS	
15. MOTHER'S MAIDEN NAME NELLIE SMITH		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 215-10-2025		18. INFORMANT ADDRESS W. CARLOS O. FOX (SAME)	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arterio sclerotic Cardio Vascular Disease.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner H. Spitz		DEPUTY CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4.5.70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-7-70	
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1970		25B. NAME OF REGISTRAR Robert E. Varney, M.D.	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons		ADDRESS 4905 York Rd. Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

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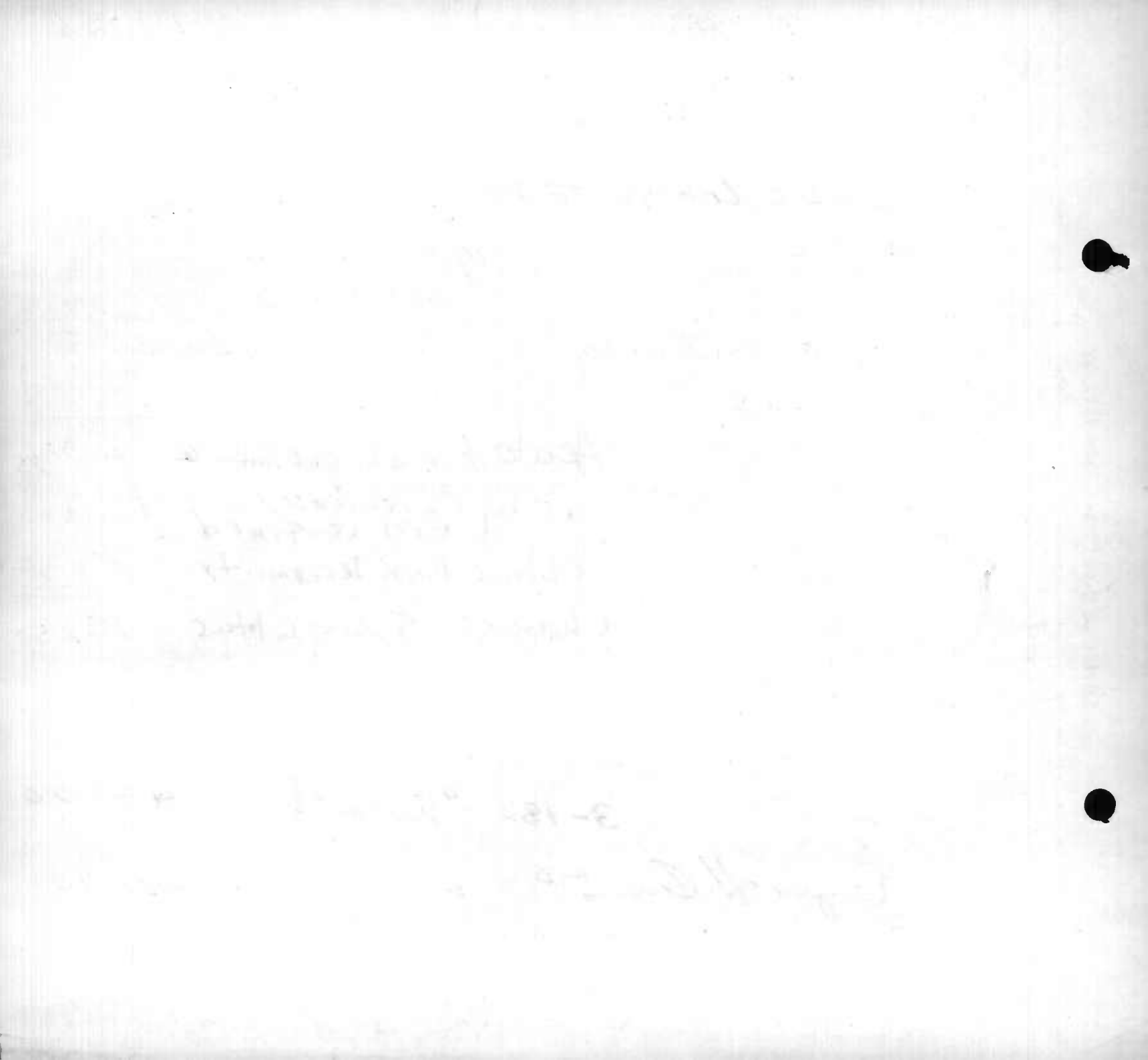
BALTIMORE CITY HEALTH DEPARTMENT				X	REG. NO.	70	3682
<p>P-654 70 3682</p> <p>BIRTH NO.</p>		<p>CERTIFICATE OF DEATH</p>					
<p>1. NAME OF DECEASED (Type or Print) <i>Elsie Purner</i></p>				<p>2. DATE AND HOUR OF DEATH <i>6:45 PM 4/3/70</i></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>				<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Talbot</i></p>			
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>3013 Winsor Ave. Baltimore, Maryland</i></p>				<p>C. CITY OR TOWN <i>Trappe</i></p>		<p>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>5. SEX <i>Fem.</i></p>				<p>6. RACE <i>Negro</i></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH <i>2/9/1891</i></p>				<p>9. AGE (In years last birthday) <i>79</i></p>		<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i></p>				<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <i>Maryland</i></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>				<p>13. FATHER'S NAME <i>David Brooks</i></p>			
<p>14. MOTHER'S MAIDEN NAME <i>Isabel Brooks</i></p>				<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i></p>			
<p>16. SOCIAL SECURITY NO. <i>220-03-3829A</i></p>				<p>17. INFORMANT <i>Mrs. Isabel Brown 3013 Winsor Ave. Baltimore, Maryland</i></p>			
<p>18. CAUSE OF DEATH</p>				<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Bladder</i></p>				<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>4 + months.</i></p>			
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				<p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p>			
<p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>				<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>		<p>22. I certify that (I) (this hospital) attended the deceased from <i>3-12-70</i> 19 to <i>4-3</i> 19 70, that (I) (we) last saw the deceased alive on <i>3-12-70</i> 19 and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>		<p>23A. SIGNATURE <i>Lucius W. Keeper, M.D.</i></p>	
<p>23B. DATE SIGNED <i>4-4-70</i></p>		<p>23C. PHYSICIAN'S NAME (Type) <i>Lucius W. Keeper</i></p>		<p>23D. ADDRESS <i>2231 Garrison Blvd Balto. Md.</i></p>		<p>24. LOCATION (City, town, or county) (State) <i>Trappe Talbot Maryland</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>24B. DATE <i>4/10/70</i></p>		<p>24C. NAME OF CEMETERY or CREMATORY <i>Trappe</i></p>		<p>24D. DATE REC'D BY HEALTH DEPT. <i>APR 7 1970</i></p>	
<p>25A. NAME OF REGISTRAR <i>Phyllis E. Taylor, M.D.</i></p>		<p>25B. NAME OF REGISTRAR</p>		<p>25C. FUNERAL DIRECTOR <i>The J. B. Dashiell Funeral Home</i></p>		<p>ADDRESS <i>Box 606 Easton, Md.</i></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 70 3683		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3683	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAM E. JOHNSON		4/6/1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
00322 E LAFAYETTE ST.		MARYLAND		1205	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		322 E. LAFAYETTE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	C	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/29/1896	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JAMES H. JOHNSON		CARRIE ROBINSON		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES WWI				George Johnson 2424 Lehigh Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Acute Bronchopneumonia		4 Days	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		For more than 2 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Being Chronically Bed Confined		Years	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Chronic Back Deformity			
		(C)			
II		Chronic Syngulitus		Years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4 - 1968 to 4 - 1970, that (I) (we) last saw the deceased alive on 3-18-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Eugene H. Owens M.D.		4-7-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Eugene H. Owens M.D.		1735 E. Federal St			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-4-70		Baltimore Cat	
				Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 7 1970		D. A. E. Fisher, M.D.		E. Owens 1000 B. Hanley Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3684	
11-633 70 3684		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Meredith Maggie</i>		3-28-70 7:14 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View Ncc</i>		A. STATE <i>MD</i> B. COUNTY <i>Spring Court 301</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Negro</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-1-98</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <i>71</i>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <i>John W Wolford</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Crash</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-12-0758</i>	
17. INFORMANT <i>Chant</i>		ADDRESS	
18. <i>412.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>ASCVD + HCD</i> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mths</i>	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Heart Failure</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Bot. Hemiparesis</i>	
(C) <i>Bot. Hemiparesis</i>		<i>Months</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(he)</i> (this hospital) attended the deceased from <i>12 March</i> 19 <i>70</i> to <i>27 March</i> 19 <i>70</i> that <i>(he)</i> (we) last saw the deceased alive on <i>27 March</i> 19 <i>70</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(he)</i> (we) (did) (did not) view the body after death.			
23A. SIGNATURE <i>A.C. Aleizator</i>		23B. DATE SIGNED <i>28 March 70</i>	
23C. PHYSICIAN'S NAME (Type) <i>A.C. ALEIZATOR</i>		23D. ADDRESS <i>1209 50. Paul St. Balto, Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 8 1970</i>		25B. NAME OF REGISTRAR <i>E. Taylor, Jr.</i>	
25C. FUNERAL DIRECTOR <i>Brown Sons & S.</i>		ADDRESS	

SECRET

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 3685	
<p>W-400 70 3685</p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) EARL R. WHALEY</p>		<p>2. DATE AND HOUR OF DEATH 9/3/70 7:30 P.M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>37 Mercy Hospital</p>			<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY ANNE ARUNDEL</p> <p>C. CITY OR TOWN PASADENA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 242 CARROLL RD. 21122</p>		
<p>5. SEX M 6. RACE W</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH 6/22/21 9. AGE (In years last birthday) 48</p>			
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>Engineer</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p>Genl Services Admin</p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p>Balto, Md</p>	
<p>12. CITIZEN OF WHAT COUNTRY?</p> <p>USA</p>			<p>13. FATHER'S NAME James L Whaley</p>		
<p>14. MOTHER'S MAIDEN NAME Fanny Robinson</p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>Yes WW II</p>		
<p>16. SOCIAL SECURITY NO.</p>			<p>17. INFORMANT ADDRESS</p> <p>James L Whaley 242 Carroll Rd Pasadena, Md</p>		
<p>18. 442 X I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p> <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> <p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (1) this hospital attended the deceased from 3/30 19 70 to 4/3 19 70 that it (we) last saw the deceased alive on 4/3 19 70 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) He (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE MANUELA H. RIBEIRO, M.D.</p>				<p>23B. DATE SIGNED 4/30/70</p>	
<p>23C. PHYSICIAN'S NAME (Type) MANUELA H. RIBEIRO, M.D.</p>				<p>23D. ADDRESS</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p>Burial</p>		<p>24B. DATE 4/8/70</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Balto Nat'l Cemetery</p>	
<p>24D. LOCATION (City, town, or county) (State)</p> <p>Catonsville Balto Md</p>		<p>25A. DATE REC'D BY HEALTH DEPT. APR 8 1970</p>			
<p>25B. NAME OF REGISTRAR Robert E. Tabor, M.D.</p>		<p>25C. FUNERAL DIRECTOR ADDRESS McElly FH 237 Patapsco Ave. 21225</p>			

11

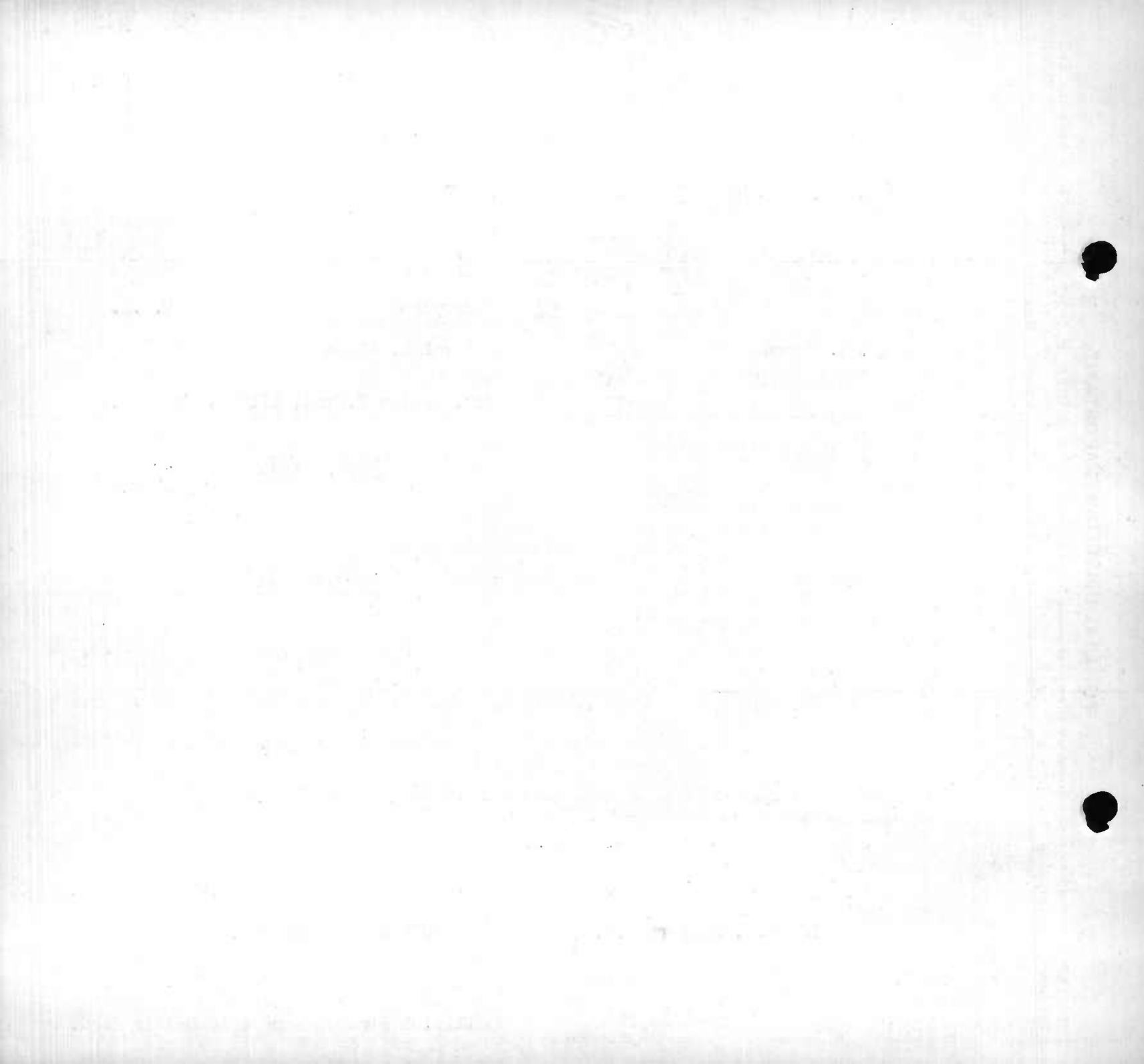
11

MANUEL J. ROBERTS, JR.
MANUEL J. ROBERTS, JR.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

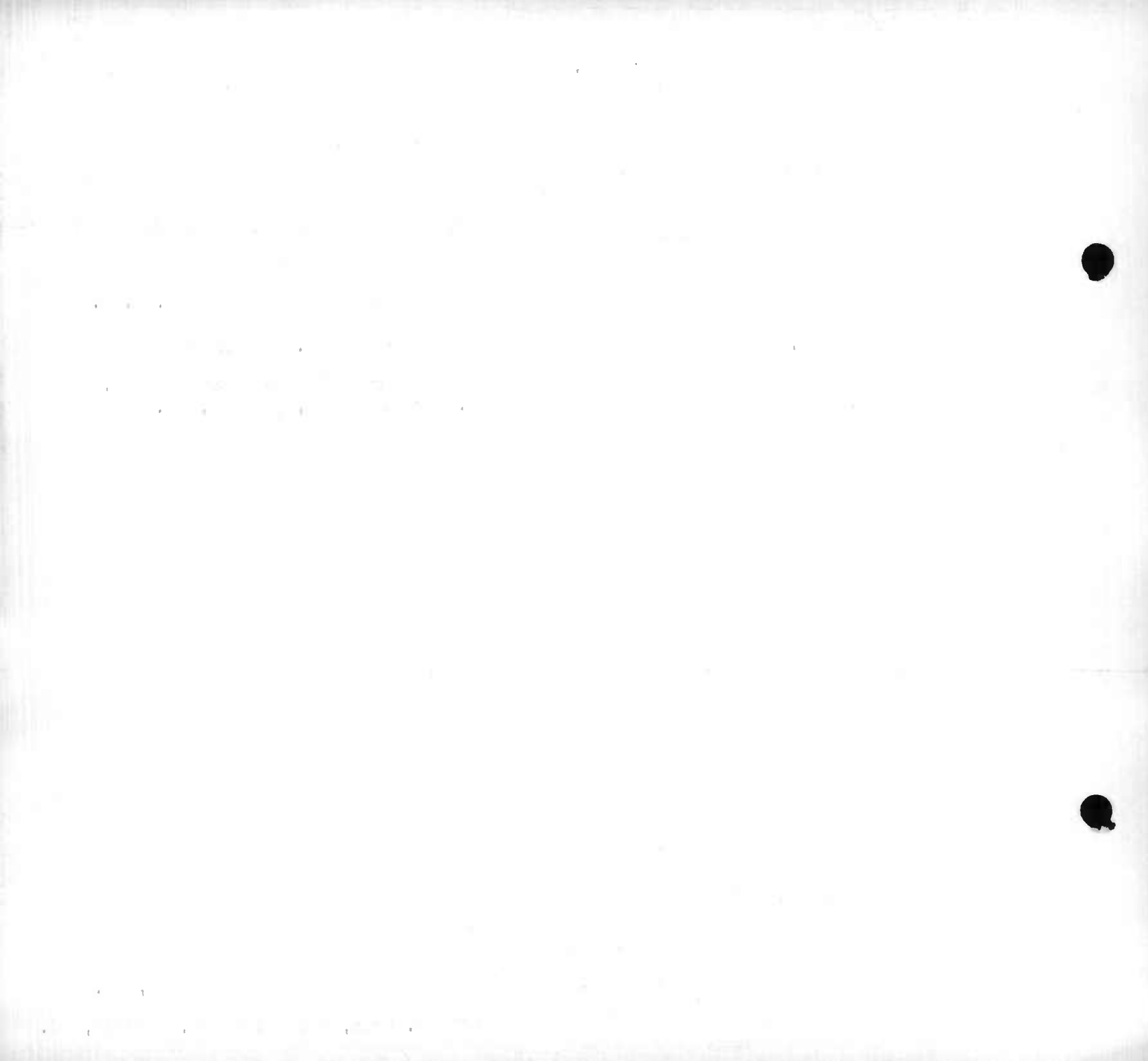
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3686	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Mary V. Benny		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> April 6, 1970 2 A.M. M. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Ardleigh Nursing Home 2095 Rockrose Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> A. STATE Maryland B. COUNTY 902 </div> <div style="display: flex; justify-content: space-between;"> C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div> <div style="display: flex; justify-content: space-between;"> E. STREET AND NUMBER 1713 E. 35th St. </div>			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1878		9. AGE (In years last birthday) 91
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lloyd H. Crown			
14. MOTHER'S MAIDEN NAME Sarah E. Allen		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Marion E. Hird, 1713 E. 35th St.,			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE ARTERIO-SCLEROTIC CARDIO DUE TO, OR AS A CONSEQUENCE OF: VASCULAR DISEASE 15 YRS. (B) DUE TO, OR AS A CONSEQUENCE OF: DIABETES MELLITUS (C) 5 YRS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 1968 to APRIL 6 1970, that (I) (was) last saw the deceased alive on APRIL 25 1970 and that in (my) (own) opinion a death occurred on the date and hour and from the causes stated above. (I) (will) (did) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor		23B. DATE SIGNED APRIL 7 1970		23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M.D.	
23D. ADDRESS 3902 Greenmount Ave.,		24. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 4/8/70		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

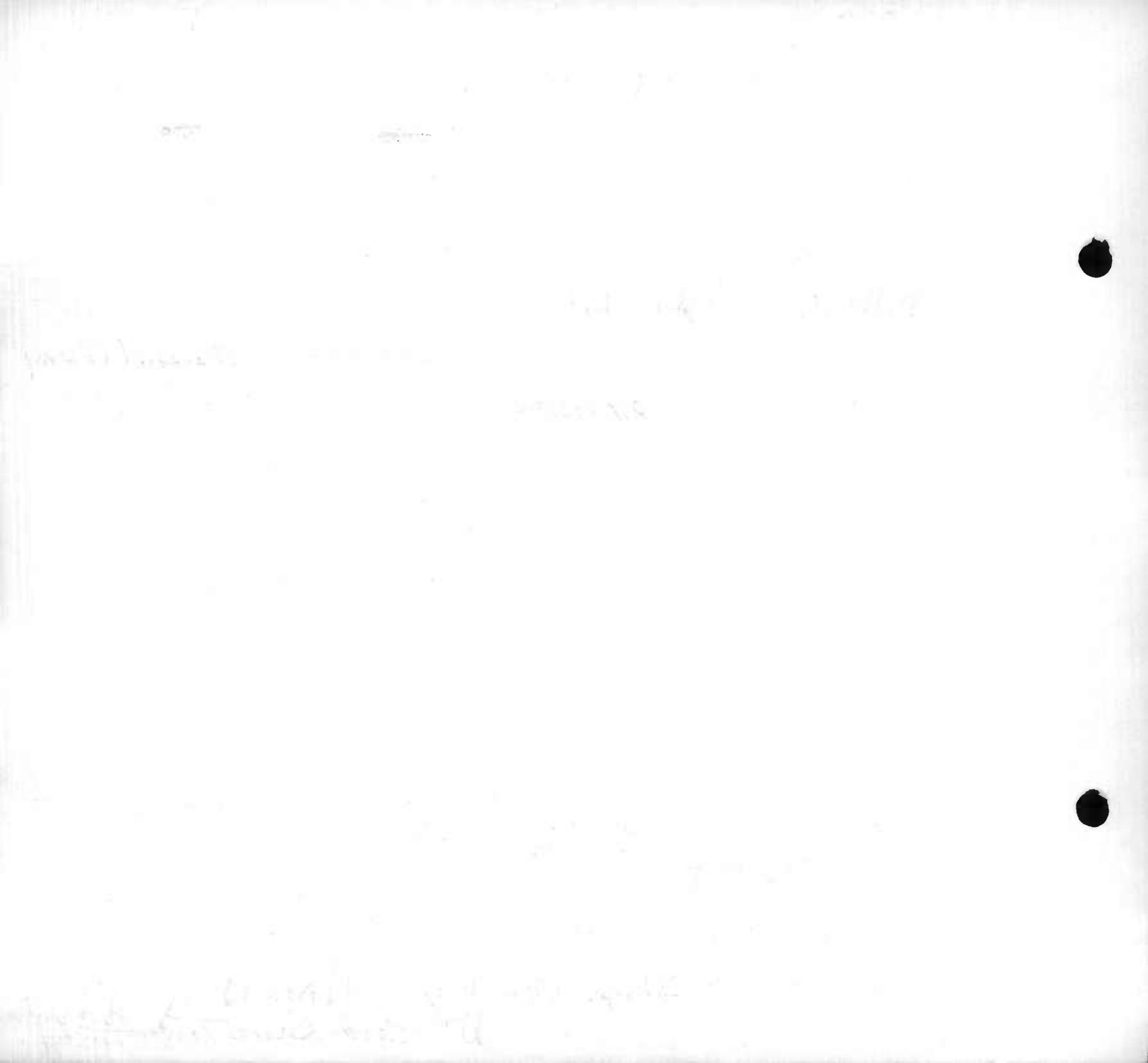
W-340 70 3687		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3687	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Weddle Cora</u>		2. DATE AND HOUR OF DEATH <u>April 6, 1970</u> <u>5:40 P. M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Conv. Center</u> <u>213 Light St. Balt. Md</u> <u>21230</u>		E. STREET AND NUMBER <u>7461 Lawrence Rd</u> <u>21222</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-35</u>	9. AGE (In years last birthday) <u>34</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never worked</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Henry A. Weddle</u>		14. MOTHER'S MAIDEN NAME <u>Gladys C. Vernon</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Mother) <u>7461 Lawrence Rd.</u> <u>Mrs. Gladys Weddle, Dundalk, Md. 21222</u>	
18. <u>315.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Status Epilepticus</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Mental Retardation</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 4</u> 19 <u>70</u> to <u>April 6</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>April 6</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Adoracion B. Paulino</u>		23B. DATE SIGNED <u>April 6, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>Adoracion B. Paulino</u>		23D. ADDRESS <u>401 MED. ARTS BLDG, Balt. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/9/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Dorsey, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 8 1970</u>		25B. NAME OF REGISTRAR <u>John E. ...</u>		25C. FUNERAL DIRECTOR <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

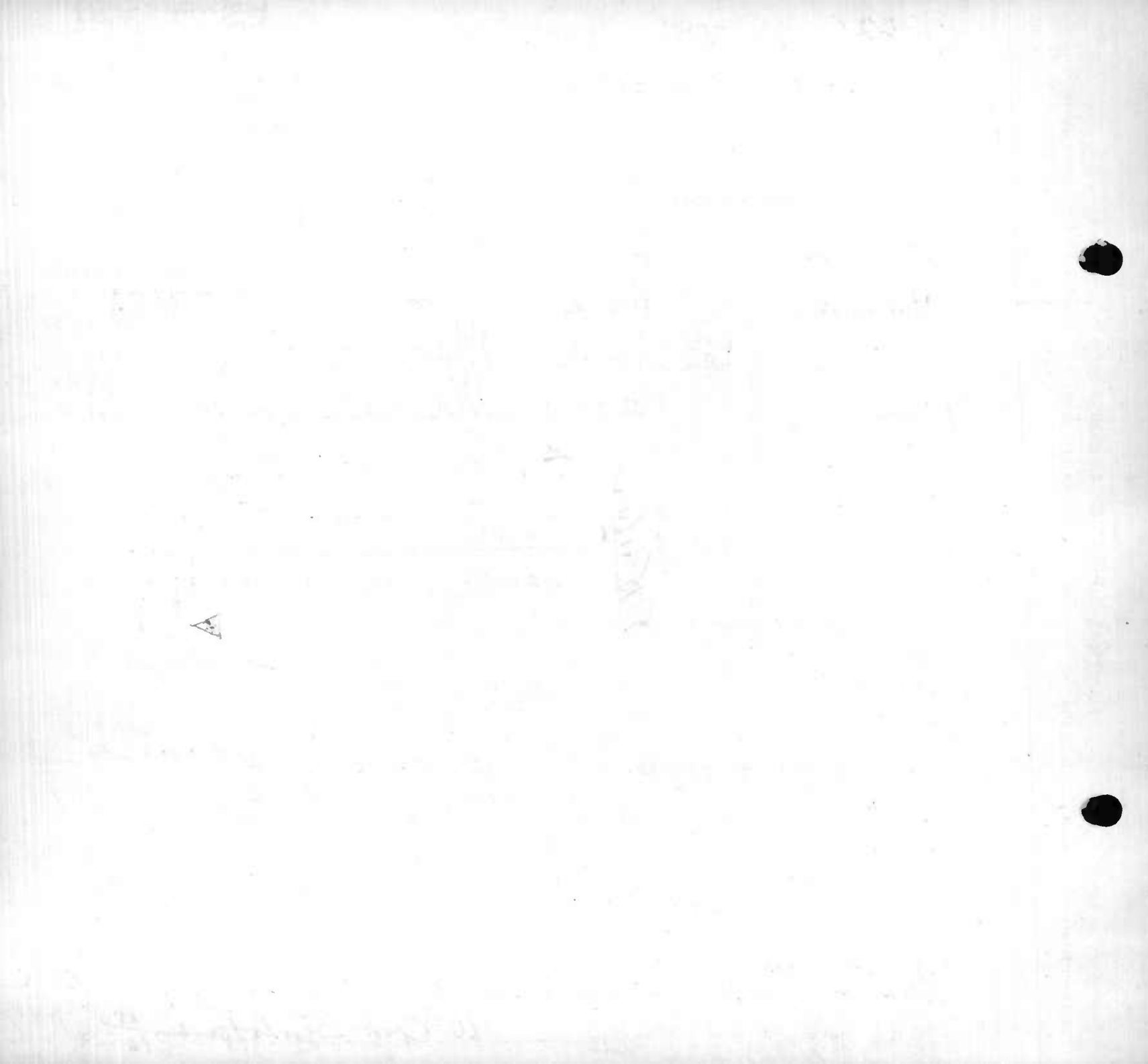
L-300 70 3688				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3688	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LLOYD MR. JOSEPH W.				2. DATE AND HOUR OF DEATH 4-2-1970 4:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Maryland		B. COUNTY 1206	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2008 Maryland			
5. SEX M	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/21/48		9. AGE (in years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attend.		10B. KIND OF BUSINESS OR INDUSTRY Parking Lot		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.N.	
13. FATHER'S NAME JOS. D. LLOYD.				14. MOTHER'S MAIDEN NAME Unknown Margaret GRAY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 291096594		17. INFORMANT Mrs. John J. Bowman ADDRESS 3138 WISEMAN WASH. D.C.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Myocardial Infarction Generalized Atherosclerosis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Heart Failure (B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (C) Generalized Atherosclerosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cerebral Vasculor A-S.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-9-1970 to 4-2-1970 that (I) (we) last saw the deceased alive on 4-2-1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Fateh				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-2-70	
23C. PHYSICIAN'S NAME (Type) M. FATEH				23D. ADDRESS MD. Gen. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/6/70		24C. NAME OF CEMETERY OR CREMATORY Shoops Cemetery		24D. LOCATION (City, town, or county) (State) Harrisburg Penn	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson		ADDRESS 1050 York Rd. Towson	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

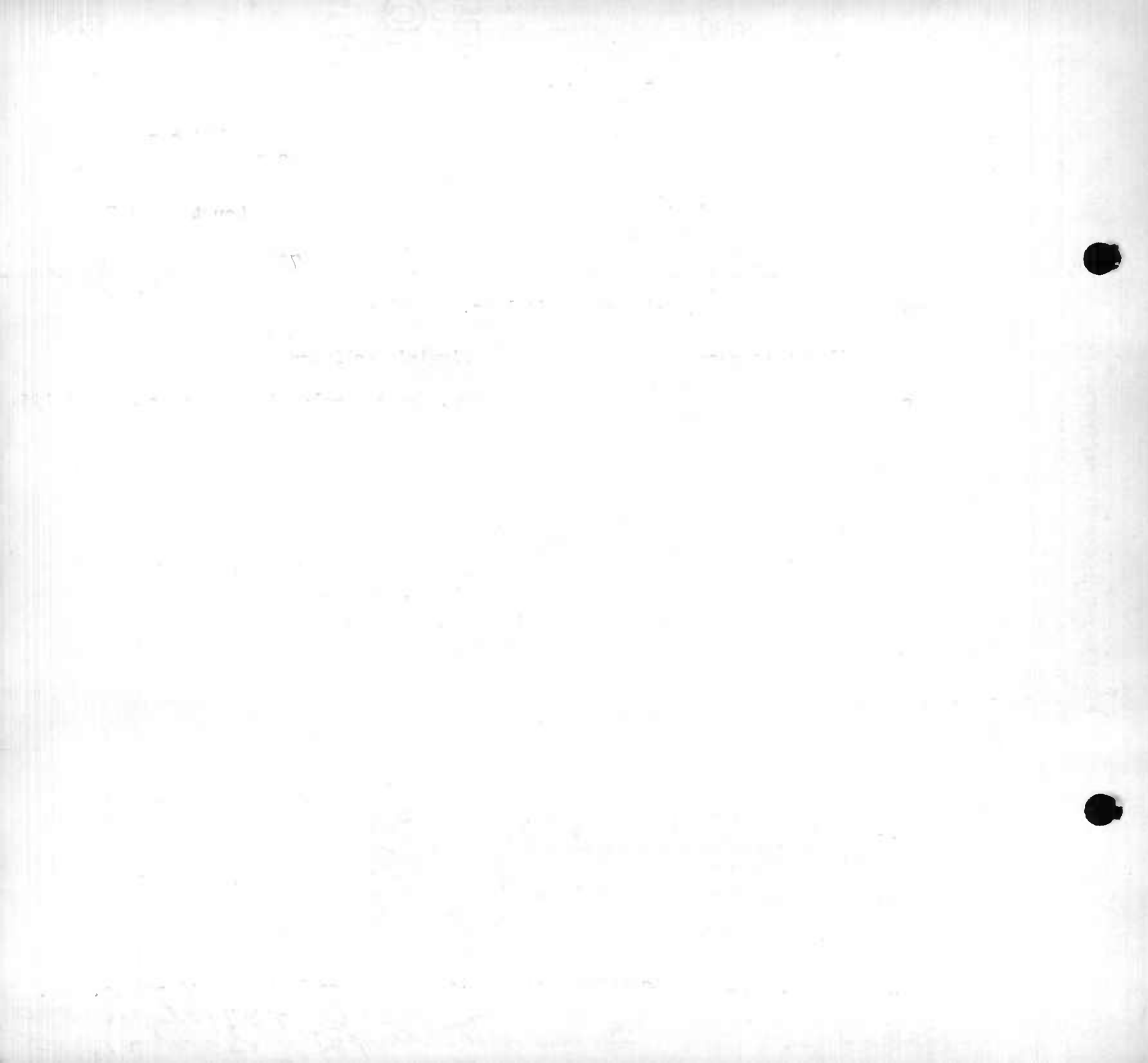
BIRTH NO. M-620 70 3689		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3689	
1. NAME OF DECEASED (Type or Print) Myers, Mary Ellen			2. DATE AND HOUR OF DEATH 4-6-70 2.05 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 45 The Good SAMARITAN HOSPITAL			A. STATE MD B. COUNTY BALTIMORE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 1718 B. Edgewood Rd. 21234		
5. SEX F.	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1880	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) OHIO	
13. FATHER'S NAME Personette		14. MOTHER'S MAIDEN NAME Margaret A. Holiday		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 2-70116100		17. INFORMANT MARGARET M. Nizer ADDRESS Same	
18. 440191-2887		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fracture - Left Hip - operated		26 days	
(This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) Generalized Arteriosclerosis			
ANTECEDENT CAUSES		(C) Chronic Lung Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 3-9-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture - Left Hip		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify "medical examiner")		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1718 Edgewood Rd. Apt. 5	
21D. TIME OF INJURY (APPROX.) 3 26 70 734		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? collapse	
22. I certify that (I) (this hospital) attended the deceased from 3-26-1970 to 4-6-1970 , that (I) (we) lost saw the deceased alive on 4-5-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. Gland			23B. DATE SIGNED 4/6/70		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 4/8/70		
24C. NAME OF CEMETERY or CREMATORY Lorraine Park Woodlawn			24D. LOCATION (City, town, or county) MD		
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970			25B. NAME OF REGISTRAR Wm. Cook		
25C. FUNERAL DIRECTOR Brooks Townsend			25D. ADDRESS 1058 York		



FUNERAL DIRECTOR: IMPORTANT

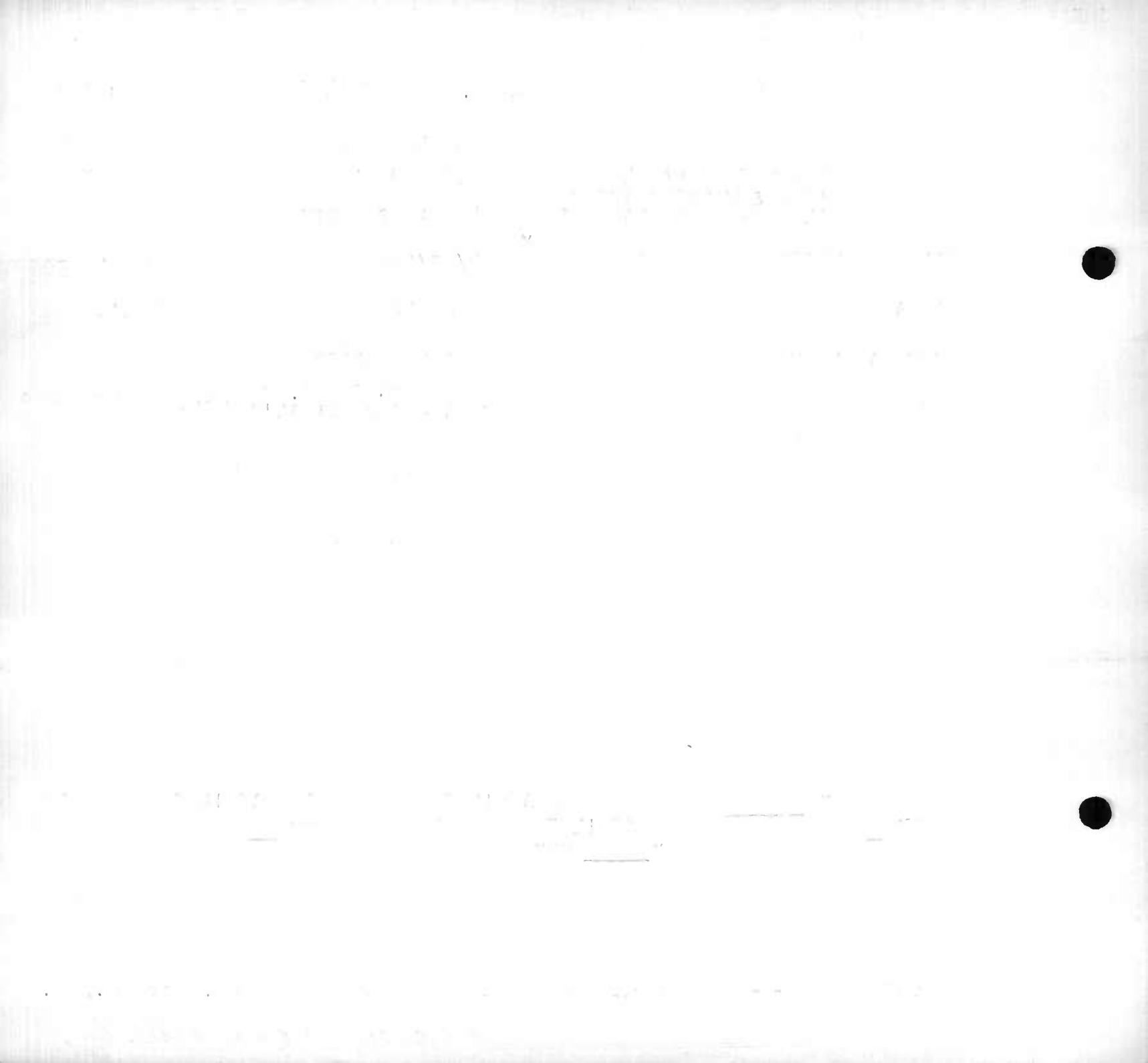
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3690	
1-525 70 3690		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HARVEY L. JOHNSON		2. DATE AND HOUR OF DEATH 4/4/70 11:05p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		A. STATE MARYLAND B. COUNTY Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 9730 ASHBURTON ST. BALT. MD 21216		C. CITY OR TOWN Randallstown D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1 KORADO Court 21207	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1891
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY Davidson Chemical Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Johnson		14. MOTHER'S MAIDEN NAME Virginia Robinson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mrs. Grace Arnold	
		ADDRESS 436 Patapsco Ave. 21225	
18. 4123 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (C) A S HT Disease & Atrial Fibrillation	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). probable pneumonia Rt base of lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 49 hrs	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 4/2/70 19 70 to 4/4/70 19 70 , that (I) (we) last saw the deceased alive on 4/4/70 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Subash C. Ahuja M.D.		23B. DATE SIGNED 4/4/70	
23C. PHYSICIAN'S NAME (Type) SUBASH C. AHUJA M.D.		23D. ADDRESS 730 ASHBURTON ST. BALT. MD. 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/8/70	24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	24D. LOCATION (City, town, or county) (State) Woodlawn, Baltimore Co. Md.
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR P. E. Fisher M.D.	
		25C. FUNERAL DIRECTOR McGulley H. 737 Patapsco ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

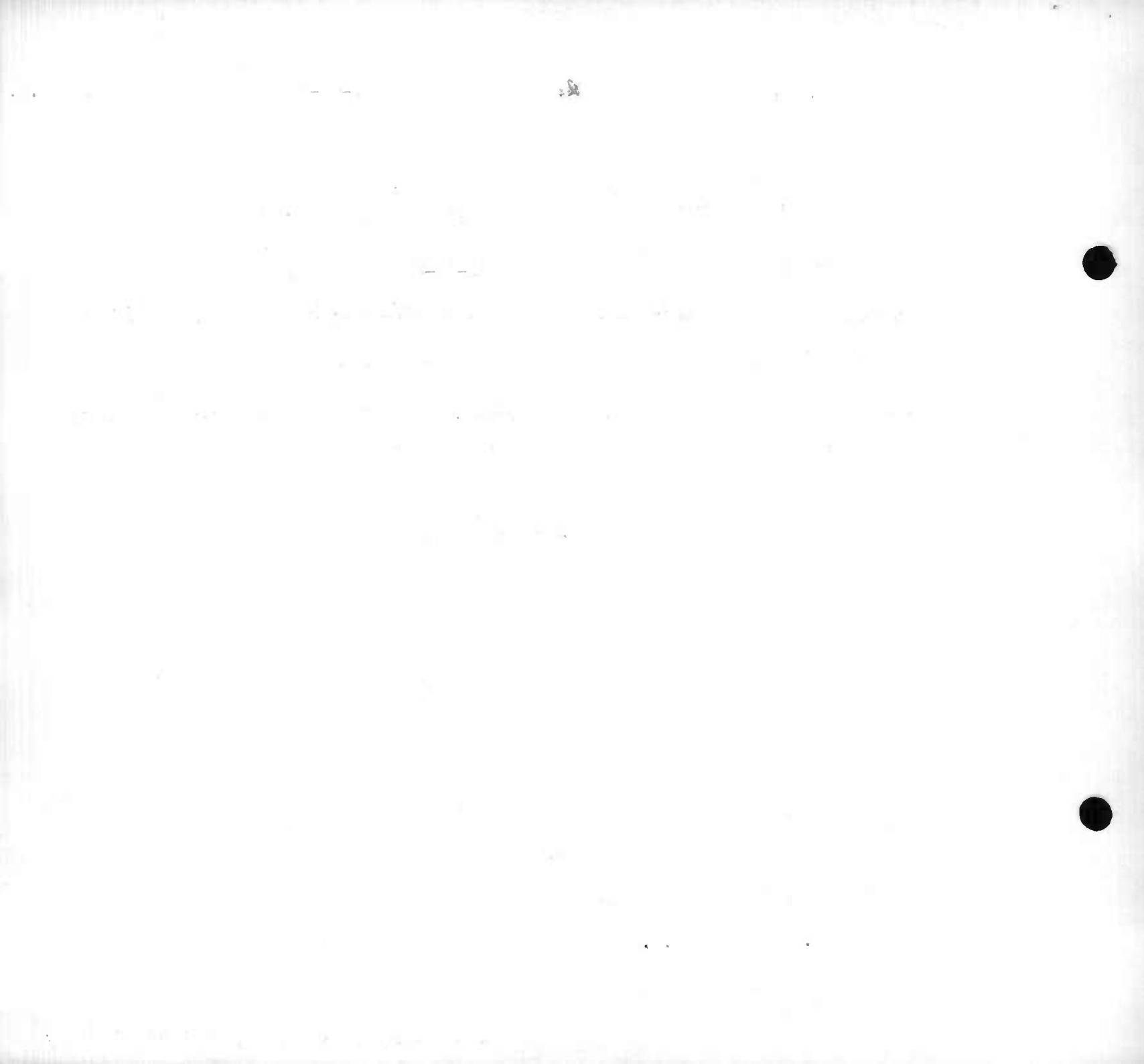
JMK		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3691	
<p>S-426 70-06324 3691</p> <p>BIRTH NO. 70-06324</p>		<p>CERTIFICATE OF DEATH</p>			
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;">SLUSHER, BABY BOY MARK W.</p>		<p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;">APRIL 5, 1970 6:00 A. M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="text-align: center;">40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY ANNE ARUNDEL 52001061</p> <p>C. CITY OR TOWN GLEN BURNIE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 400 ARBOR DRIVE</p>			
<p>5. SEX</p> <p>MALE</p>	<p>6. RACE</p> <p>WHITE</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p>04/05/70</p>	<p>9. AGE (In years last birthday)</p> <p>4 50</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>INFANT</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p>MARYLAND</p>	<p>12. CITIZEN OF WHAT COUNTRY?</p> <p>U.S.A.</p>
<p>13. FATHER'S NAME</p> <p>JOHN A SLUSHER</p>		<p>14. MOTHER'S MAIDEN NAME</p> <p>MARY M NARER</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>NO</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS</p> <p>Mr. John A. Slusher, 400 Arbor Drive ST AGNES HOSPITAL'S RECORDS</p>	
<p>18. 776.9 I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ASPHYXIA NEONATORUM</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>PREMATURITY</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p> <p>0</p>					
<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>					
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>			
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (X) (this hospital) attended the deceased from APRIL 5 19 70 to APRIL 5 19 70 and that (we) last saw the deceased alive on APRIL 5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE</p> <p style="text-align: center;"><i>[Signature]</i></p>		<p>23B. DATE SIGNED</p> <p style="text-align: center;">4-6-70</p>		<p>23C. PHYSICIAN'S NAME (Type)</p> <p style="text-align: center;">JORGE GARCIA</p>	
<p>23D. ADDRESS</p> <p style="text-align: center;">ST AGNES HOSP</p>		<p>23E. DEGREE</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p>Burial</p>		<p>24B. DATE</p> <p>4-7-70</p>		<p>24C. NAME OF CEMETERY or CREMATORY</p> <p>Meadowridge Cemetery</p>	
<p>24D. LOCATION (City, town, or county) (State)</p> <p>Washington Blvd. Howard Co., Md.</p>		<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p>APR 8 1970</p>			
<p>25B. NAME OF REGISTRAR</p> <p>Robert E. Farber, M.D.</p>		<p>25C. FUNERAL DIRECTOR ADDRESS</p> <p>W.H. Hurlbert 5741 4107 Wilkens Ave.</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

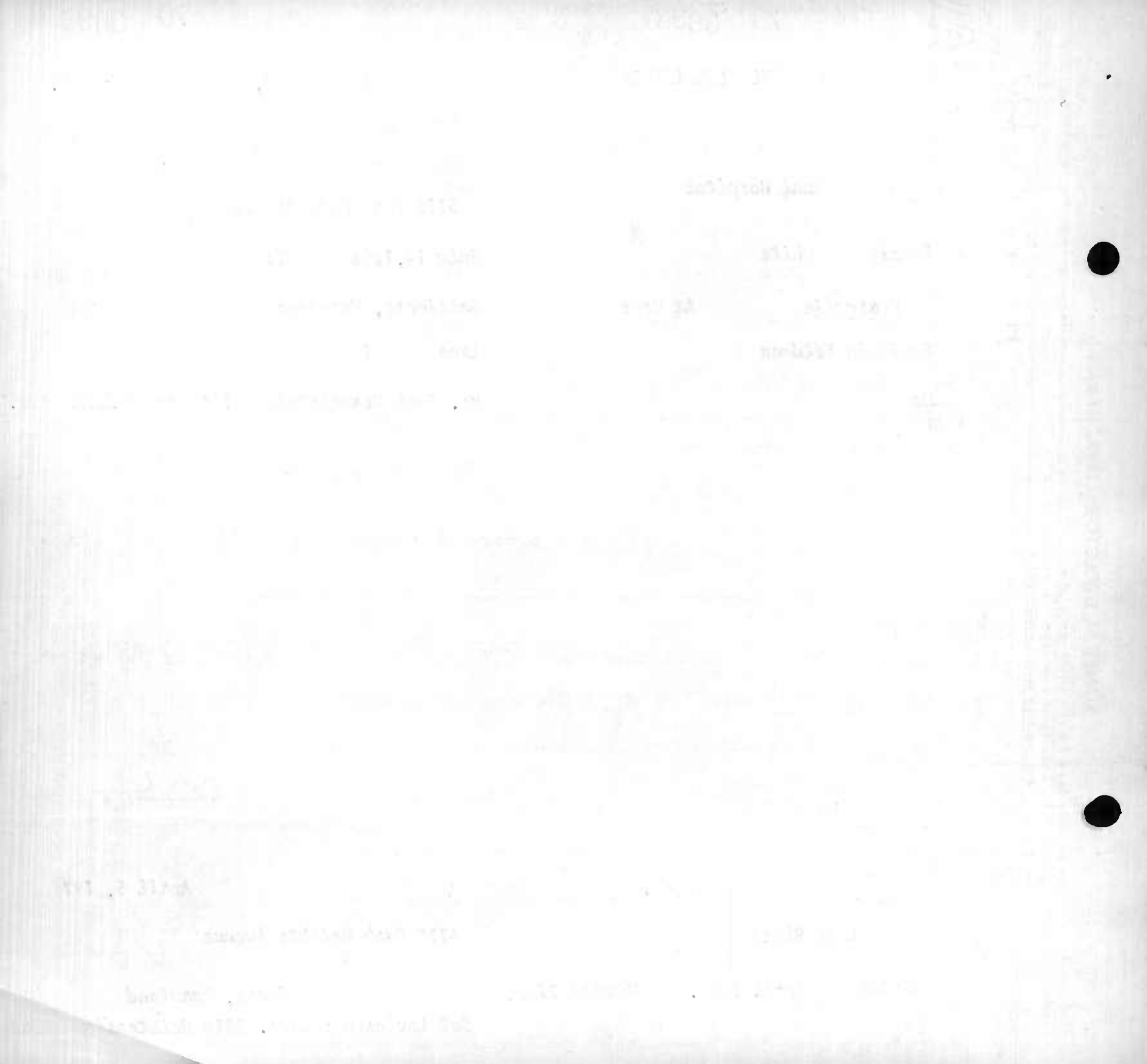
G-430 70 3692		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3692	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GOULD, JOSEPH		04-03-70 10:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		CANADA		V-50	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		LYNDEN, ONTARIO		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		P.O. Box 100			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11-10-22	47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
APPLE		GROWER		CZECHOSLOVAKIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
MORRIS GOLD		ALICE REISS		CANADA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		No		MRS. LILLY GOULD, P.O. Box 100, LYNDEN, O., CANADA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) H/O pulmonary embolus			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3/24 1970 to 4/3 1970		that (I) last saw the deceased alive on 4/3 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED			
James L. Bolen M.D.		4/3/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JAMES L. BOLEN M.D.		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
REMOVAL-BURIAL		4/4/70		ANSHE SHOLOM	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 8 1970		E. J. Bolen M.D.		SOL LEVINSON + BROS., 6010 REISTERSTOWN RD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3693	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) JEANETTE MERMELSTEIN		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> April 4, 1970 8:07 P. M. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2720 5. CITY OR TOWN Baltimore 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER 6116 Park Heights Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1898	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Benjamin Feldman		14. MOTHER'S MAIDEN NAME Lena ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Jack Mermelstein ADDRESS 6116 Park Heights Ave.	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hrs 5 hrs </div> </div> <div style="margin-top: 10px;"> (A) IMMEDIATE CAUSE Cerebral vascular hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) </div>					
MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> 19A. DATE OF OPERATION 0 </div> <div style="width: 30%;"> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED </div> <div style="width: 30%;"> 20A. AUTOPSY? (Yes or No) </div> <div style="width: 30%;"> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> </div> <div style="width: 45%;"> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) </div> <div style="width: 45%;"> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> 21F. HOW DID INJURY OCCUR? </div> </div> <div style="margin-top: 10px;"> 22. I certify that (I) (this hospital) attended the deceased from Jan 1970 to April 1970, that (I) was lost saw the deceased alive on April 4 1970 and that in (my) four opinion death occurred on the date and hour and from the causes stated above. (I) Was (did) (did not) view the body after death. </div>					
23A. SIGNATURE Leon Sheer				23B. DATE SIGNED April 5, 1970	
23C. PHYSICIAN'S NAME (Type) Leon Sheer				23D. ADDRESS 6715 Park Heights Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 5/70		24C. NAME OF CEMETERY or CREMATORY Shaarei Zion,	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 8 1970 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR Sol Levinson & Bros. ADDRESS 6010 Reisterstown Road					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
BIRTH NO. R-251				70 3694	
1. NAME OF DECEASED (Type or Print) ROSENFELD, SAMUEL				2. DATE AND HOUR OF DEATH APRIL, 4, 1970 7:10 P.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION GOOD SAMARITAN HOSPITAL				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 1019 EVANSWAY 21205	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. GOV'T.		10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME DAVID ROSENFELD			14. MOTHER'S MAIDEN NAME ROSE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 218036566		
17. INFORMANT MRS. SARA EVRY, 1000 EVANSWAY #21205			ADDRESS ARMISTEAD GARDENS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Intractable Pulmonary Edema				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 2 1970 to April 4 1970 , that (I) (we) last saw the deceased alive on 4/4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David M. Capuzzi, MD				23B. DATE SIGNED 4/4/70	
23C. PHYSICIAN'S NAME (Type) David M. Capuzzi, MD				23D. ADDRESS Good Samaritan Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-6-70		24C. NAME of CEMETERY or CREMATORY MIKRO KODESH-BETH ISRAEL	
24D. LOCATION BALTIMORE, MARYLAND		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
ADDRESS REISTERSTOWN ROAD					

INVESTIGATION

W

DATE

AGE

BALTIMORE, MARYLAND

RETIRED

U.S. DEPT.

DATE

ROSENBERG

MR. SARA LANE, 1900 E. 12th St.,
Cleveland, Ohio

RECEIVED - MAY 1946

FOR INFORMATION & RECORD

FUNERAL DIRECTOR: IMPORTANT

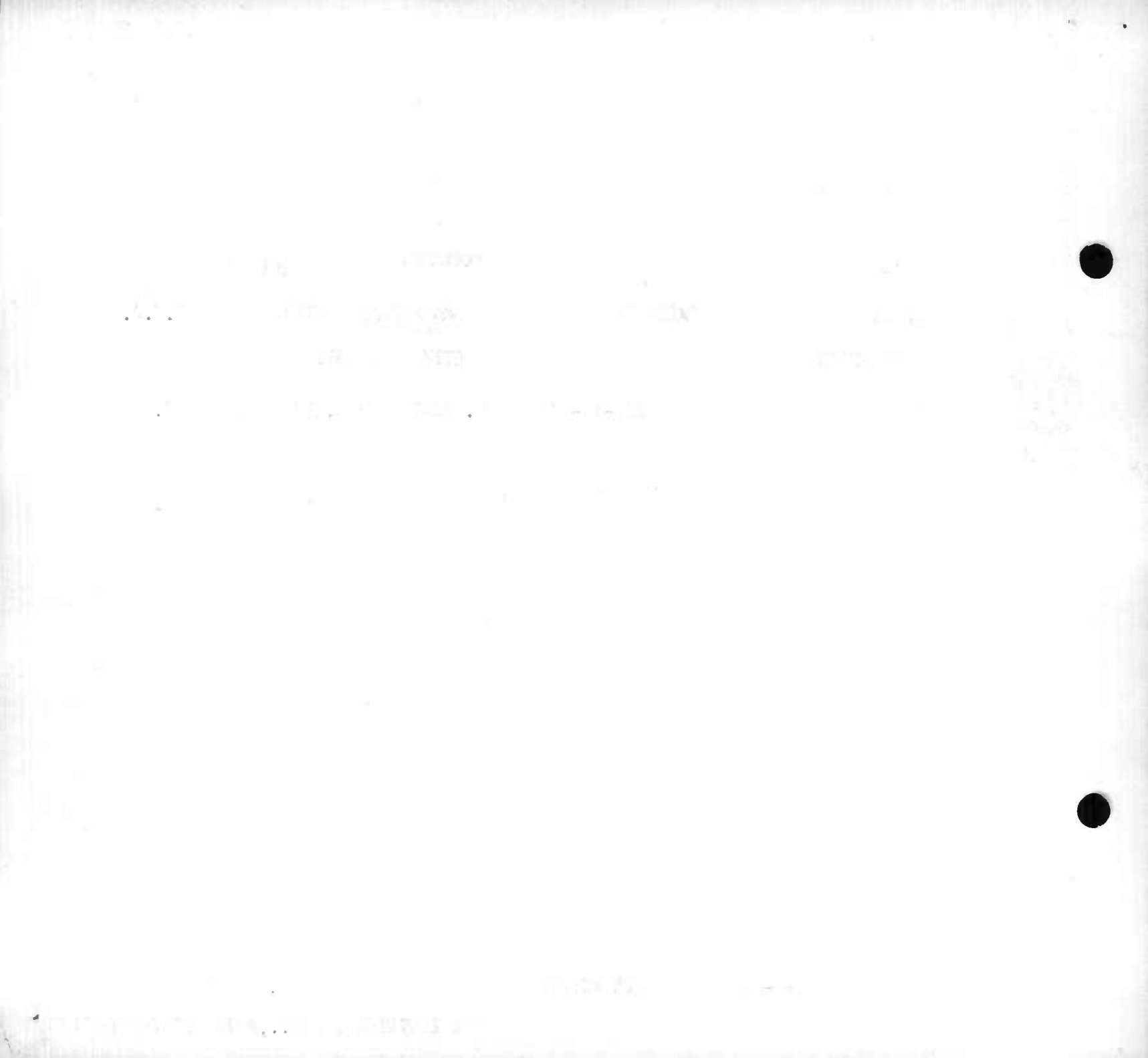
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED] 70 3695	
C-355 70 3695 BIRTH NO. 1. NAME OF DECEASED (Type or Print) GUTTMAN, EDITH		2. DATE AND HOUR OF DEATH 4/5/70 at 4:00 AM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2 SINAI HOSPITAL OF BALTIMORE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2720 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3913 CLARKS LANE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/1911	9. AGE (in years last birthday) 71 yr If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH SILBERBERG			
14. MOTHER'S MAIDEN NAME SARAH ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MR. BERTRAND GUTTMAN, 3213 SHELburne RD. #8			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SHOCK. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CEREBRO-VASCULAR ACCIDENT OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 4/3/1970 to 4/5/1970 that (I) (we) last saw the deceased alive on 4/5/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE [Signature] M.D. 23B. DATE SIGNED 4/5/70 23C. PHYSICIAN'S NAME (Type) D. NEELAM KAPOOR 23D. ADDRESS SINAI HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-6-70		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 8 1970			
25B. NAME OF REGISTRAR Charles E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3696	
S-362 70 3696				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JOSEPH STARK			2. DATE AND HOUR OF DEATH 4/5/1970 4:00 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Md. B. COUNTY 2720		
			C. CITY OR TOWN Balt 2/2/15		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 6508 Hopeton Ave.		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX	9. AGE (in years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETAIL		10B. KIND OF BUSINESS OR INDUSTRY SALESMAN		11. BIRTHPLACE (State or foreign country) AUSTRIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME AVRUM STARK		
14. MOTHER'S MAIDEN NAME ETTA KATZ			15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 215-10-3670			17. INFORMANT MR. ALVIN STARK, 4510 DRESDEN RD. #8		
18. CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause I (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). chronic abscess & sinus tract @ shoulder			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 4/2/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED sinus tract left shoulder		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/30/70 19 70 to 4/5/1 19 70 that (I) (we) last saw the deceased alive on 4/4/70 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joaquín 9058 MD.			23B. DATE SIGNED 4/5/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) JOAO CANDIDO ARAUJO			23D. ADDRESS SINAI HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-6-70		24C. NAME of CEMETERY or CREMATORY WORKMEN CIRCLE	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 8 1970			
25B. NAME OF REGISTRAR R. E. Barber, R.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



S-160

70

3697

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

3697

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EZRA SCHAPIRO

2. DATE
OF
DEATHKnown ☐
Estimated ☒

Month

Day

Year

Hour

Minute

4

4

70

11

58 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 Church Homet Hosp.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

Minute

4

4

70

12

55 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MD

Baltimore

5300

6. SEX

MALE

7. RACE

WHITE

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10-11-1907

10. AGE (In years
last birthday)

62

If Under 1 Yr. II Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

8003 B Woodgate Ct

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ABRAHAM SCHAPIRO

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MANAGER

14B. KIND OF BUSINESS OR INDUSTRY

REAL ESTATE

15. MOTHER'S MAIDEN NAME

SARAH ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

W.W. II U.S.C.G.

17. SOCIAL
SECURITY NO.

220-14-5096

18. INFORMANT

ADDRESS

MRS. MIRIAM SCHAPIRO, 8003 B WOODGATE CT.

19.

412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OFArterio Sclerosis
Cardio Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Werner H. Spitz
M.D.CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4.5.70

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

4-6-70

24C. NAME OF CEMETERY or CREMATORY

HEBREW YOUNG MEN

24D. LOCATION (City, town, or county)

BALTIMORE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 8 1970

25B. NAME OF REGISTRAR

E. J. Jaber, M.D.

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.

ADDRESS

10-11-1907
10-11-1907
10-11-1907

10-11-1907

(ALE WHITE)

10-11-1907

BALTIMORE, MARYLAND

INVESTOR

REAL ESTATE

SARAH

REGINA SCHWARTZ

10-11-1907

10-11-1907

10-11-1907

VALLEY REPORT

BALTIMORE, MARYLAND

10-11-1907

10-11-1907

10-11-1907

10-11-1907

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **70 3698**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANCES M. RAICHLEN				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 3 70 11 a M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour April 3, 1970 11 a M.			
6. SEX Female				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 8-19-1933				10. AGE (In years last birthday) 36		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME CARSON MILLER		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 5300	
15. MOTHER'S MAIDEN NAME SARAH MARKS				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO			
17. SOCIAL SECURITY NO.				18. INFORMANT ADDRESS MR. ISADOR RAICHLEN, 4117 RONIS ROAD #21208			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? RONIS 4117 Ronis Road 5300				22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 4 1 70 5 a m.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? subject ingested overdose			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Toidore Mihalakis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 4-5-70			
24C. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW				24D. LOCATION (City, town, or county) (State) REISTERSTOWN, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970				25B. NAME OF REGISTRAR Robert E. Vandyke			
				25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

ACADEMIC RECORD

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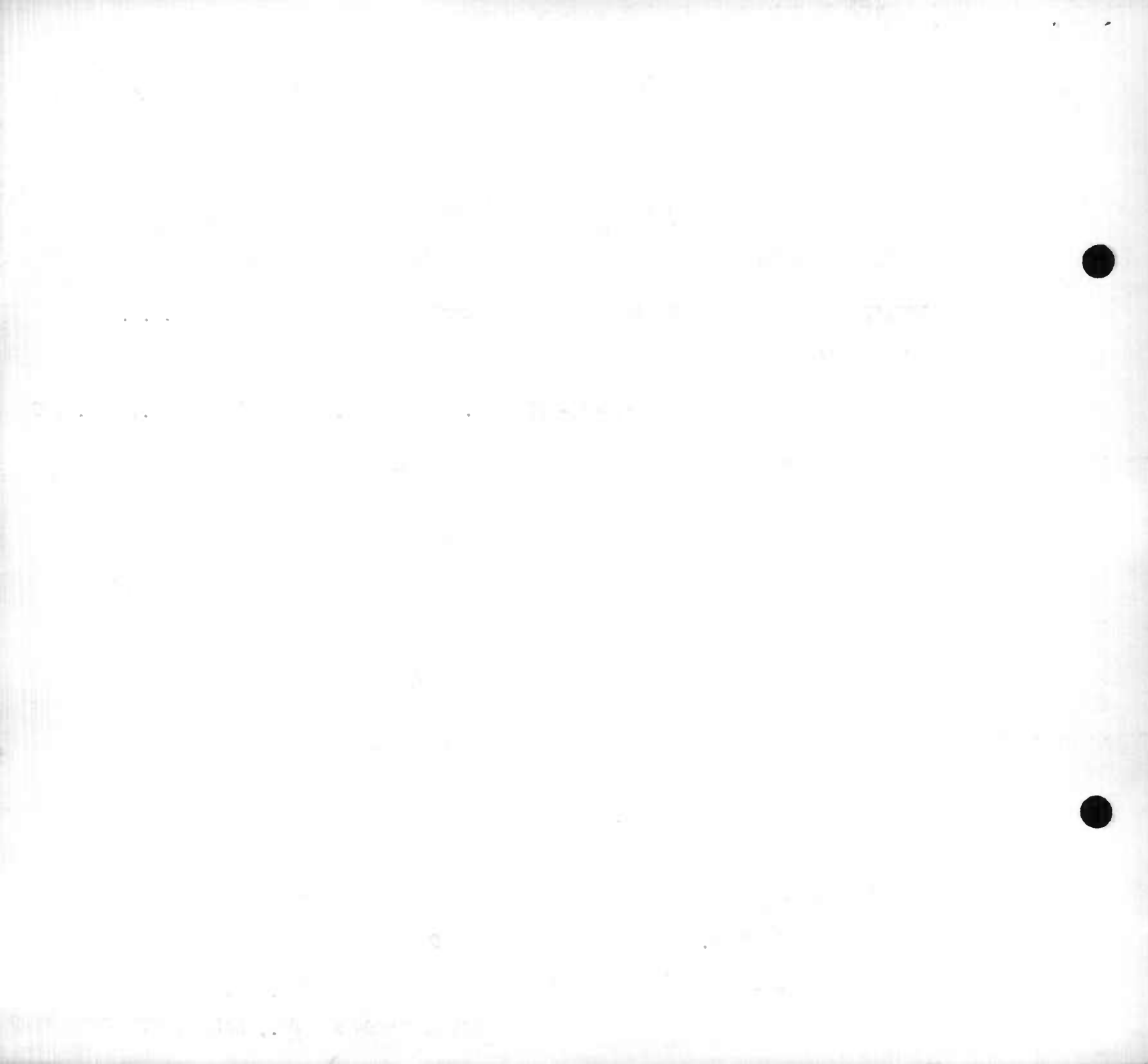
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3699</u>	
BIRTH NO. <u>F-400</u>		70 3699		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Monais Fell</u>			2. DATE AND HOUR OF DEATH <u>4/4 70</u> <u>10</u> <u>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Levinvale Hebrew Home +</u> <u>91</u>			A. STATE <u>MD</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>injury</u>			B. COUNTY <u>BALTO</u>		C. CITY OR TOWN <u>BALTO</u>
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>3545 PARK HEIGHTS AVENUE</u>
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>XXXX</u>	9. AGE (In years last birthday) <u>94</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MENS CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
13. FATHER'S NAME <u>HYMAN FELL</u>			14. MOTHER'S MAIDEN NAME <u>HELEN ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-12-2915</u>		17. INFORMANT <u>MR. LOUIS FELL, 3 COBBLESTONE CT., APT. 1 D</u>	
18. <u>4/2.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Pul Embolism</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chrom ost lung Disen</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>osteosarthritis</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> 19 <u>69</u> to <u>4/4</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/4</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ellis S Caplan M.D.</u>				23B. DATE SIGNED <u>4/4/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ELLIS S. CAPLAN</u>				23D. ADDRESS <u>LEVINDALE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-7-70</u>		24C. NAME of CEMETERY or CREMATORY <u>ANSHE NESNIA</u>	
24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 8 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
F-650 70 3700		70 3700		70 3700	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LIBBY FRANK		4-5-70 9:39 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital E.R. 1/2		A. STATE MD. B. COUNTY Baltimore Baltimore City			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN D. INSIDE CITY LIMITS?			
		Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX FEMALE 6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 7-14-17		9. AGE (In years last birthday) 52			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		AT HOME		BALTIMORE, MARYLAND U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
SAMUEL SEIDEL		GUSSIE SCHULMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		213-18-1912		MR. ALFRED L. FRANK, 627 LEAFYDALE TERR. #8	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Acute Myocardial Infarction, 1 hr	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		H. Pulmonary Edema	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 4/5/70 to 4/5/70 that (1) (we) last saw the deceased alive on 4/5/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE, SIGNED			
E. S. Kallins M.D.		4/5/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
E. S. KALLINS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		4-7-70		HEBREW YOUNG MEN	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
BALTIMORE, MARYLAND		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 8 1970		Robert E. Taylor, M.D.		SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

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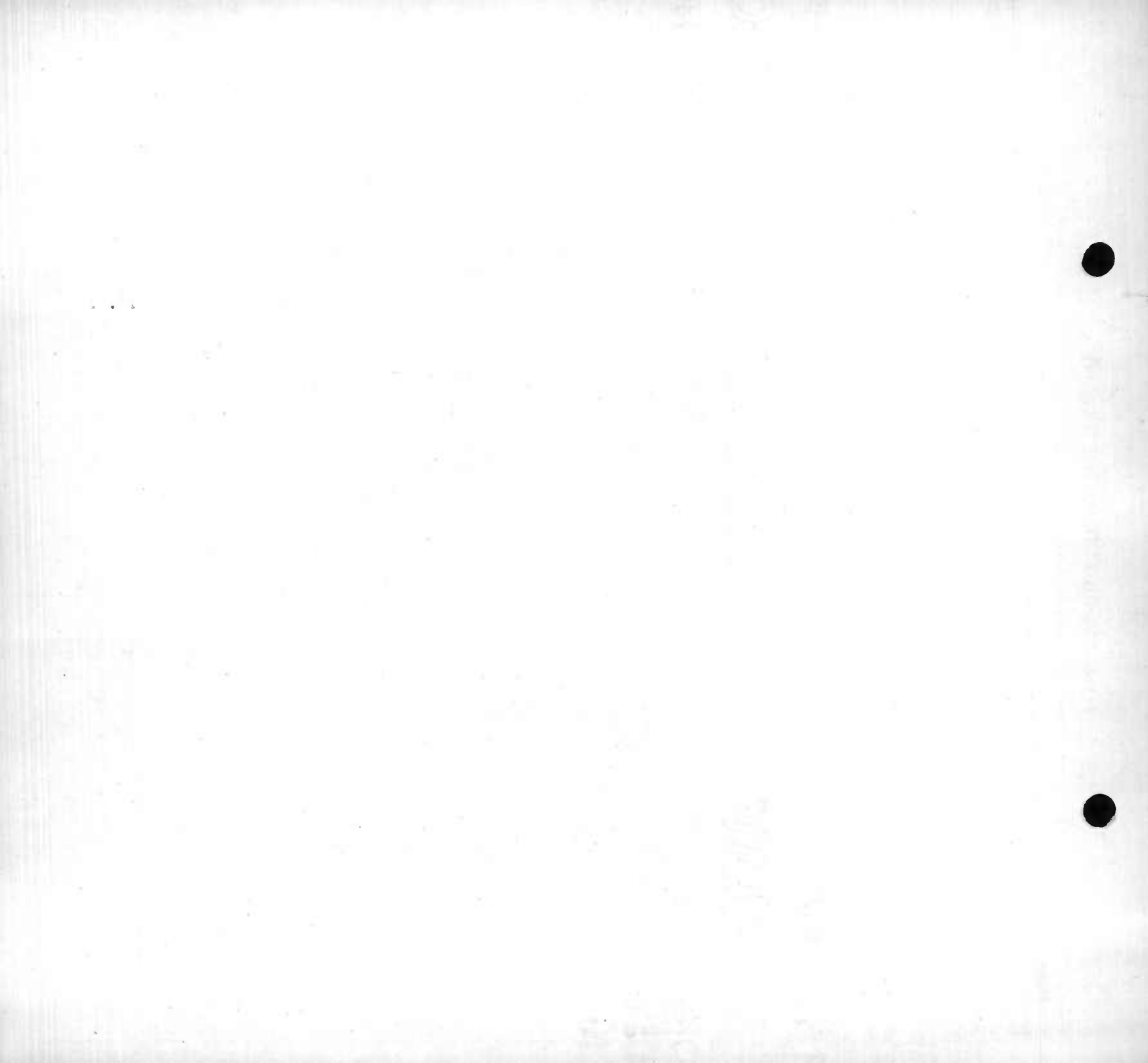
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-660 70 3701				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3701	
1. NAME OF DECEASED (Type or Print) MAMIE BREWER				2. DATE AND HOUR OF DEATH 4-4-70 8:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill NH (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MD		B. COUNTY 1501	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2415 N. Stanton St.							
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-25-84	9. AGE (In years lost birthday) 86	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHOICE HENDERSON				14. MOTHER'S MAIDEN NAME MARY BROWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 249-88-3093		17. INFORMANT Mary Cheateam		ADDRESS same	
18. 4/2.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic heart disease (B) arteriosclerosis generalized (C) 2415 N. Stanton St.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/19 1970 to 4/4 1970 , that (I) (we) last saw the deceased alive on 4/4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE ae [Signature]				23B. DATE SIGNED 4/4/70		23C. PHYSICIAN'S NAME (Type) ALLAN H. MANT MD	
23D. ADDRESS 2 E Road 88 Baltimore MD							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-8-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Blair E. Jaber, MD		25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F. H. 1348 Calhoun St.	



FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department CERTIFICATE OF DEATH				REG. NO. 70 3702
4-400 70 3702 BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		Hall, Frances R.		2. DATE AND HOUR OF DEATH 4-3-70 9:15 p. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION 39 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		Maryland 1601 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 827 N. Arlington Avenue Apt. 605		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-99	9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Charles Ennis		14. MOTHER'S MAIDEN NAME Frances Conway		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-09-3806B		17. INFORMANT Mr. Samuel Hall- Husband
18. 44091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Terminal Bronchopneumonia</u> (B) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Generalized Arteriosclerosis</u> <u>SEMI-ILEITY</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> At Work 21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>3/18</u> 19 <u>70</u> to <u>April 3</u> , 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>April 3</u> , 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Gilbert L. Bankfield</u> DEGREE 23B. DATE SIGNED 4-4-70		23C. PHYSICIAN'S NAME (Type) GILBERT L. BANKFIELD M.D. 23D. ADDRESS 722 N. Fulton Ave, Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-7-70	24C. NAME OF CEMETERY or CREMATORY Arbitus Mem. Pk.	24D. LOCATION (City, town, or county) (State) Baltimore, Md.	25A. DATE REC'D BY HEALTH DEPT. APR 8 1970
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR V. Bailey 1348 Calhoun Street		



FUNERAL DIRECTOR: IMPORTANT

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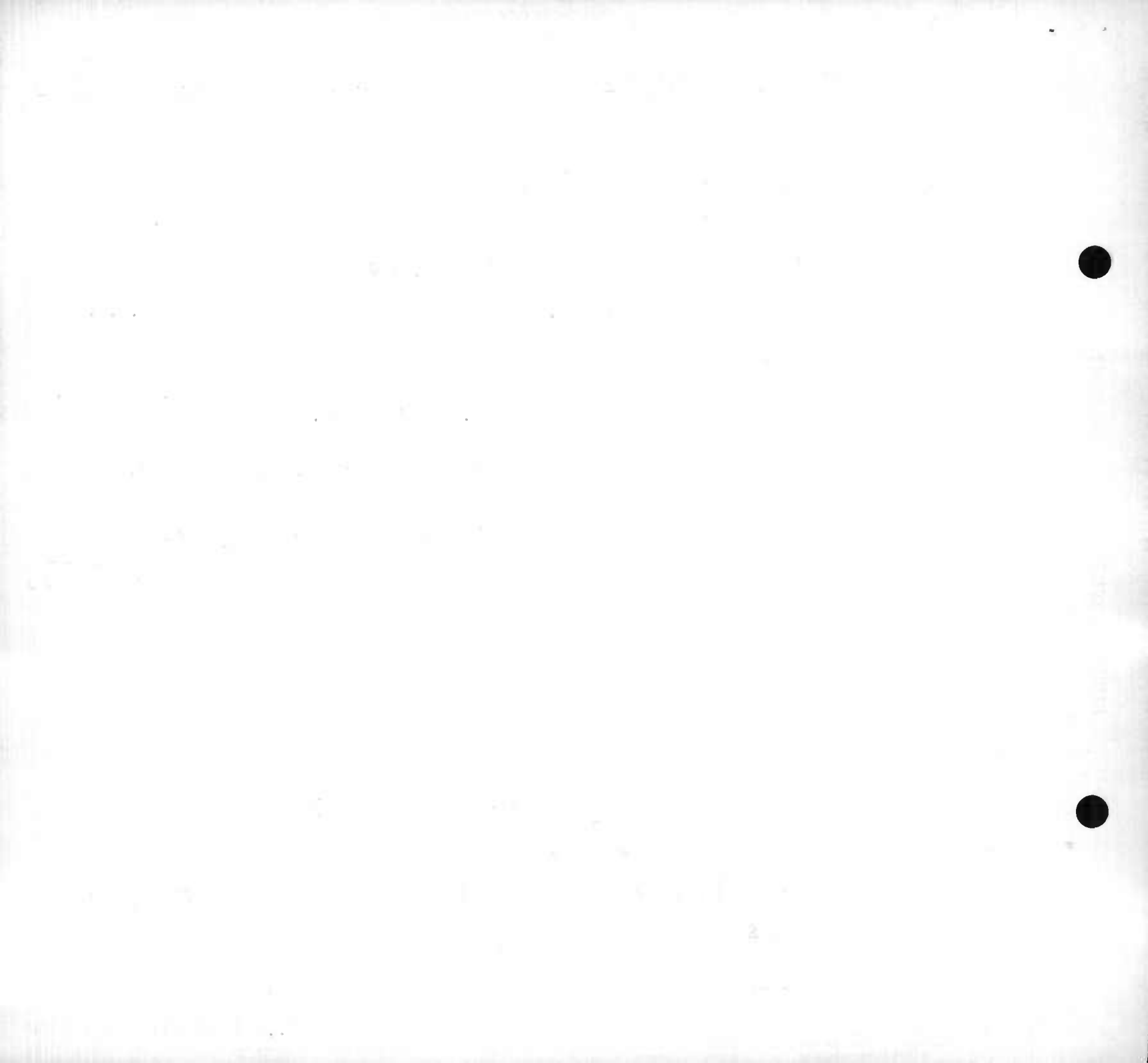
B-650 70 3703		BALTIMORE CITY HEALTH DEPARTMENT		70 3703	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		BROWN, MRS. HENRIETTA		2. DATE AND HOUR OF DEATH 4-4-1970 6:26 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 48 MD. Gen. Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 727 Lake DR.	
5. SEX F.	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-86	9. AGE (In years last birthday) 83	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME JOHN BROWN		14. MOTHER'S MAIDEN NAME LOUISANNA		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217032798		17. INFORMANT AMANDA ROBERTS, 520 MARLAND AVE. MD. 21216	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3-27-70 to 4-4-70 that (1) (we) last saw the deceased alive on 4-4-70 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE M. Fateh		23B. DATE SIGNED 4/4/70		23C. PHYSICIAN'S NAME (Type) M. FATEH	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 4-9-70		24C. NAME of CEMETERY or CREMATORY Loudon Park Nat'l. Cem.	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Robert F. Bailey, M.D.		25C. FUNERAL DIRECTOR V. Bailey Kelson F.H. 1348 Calhoun Street	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

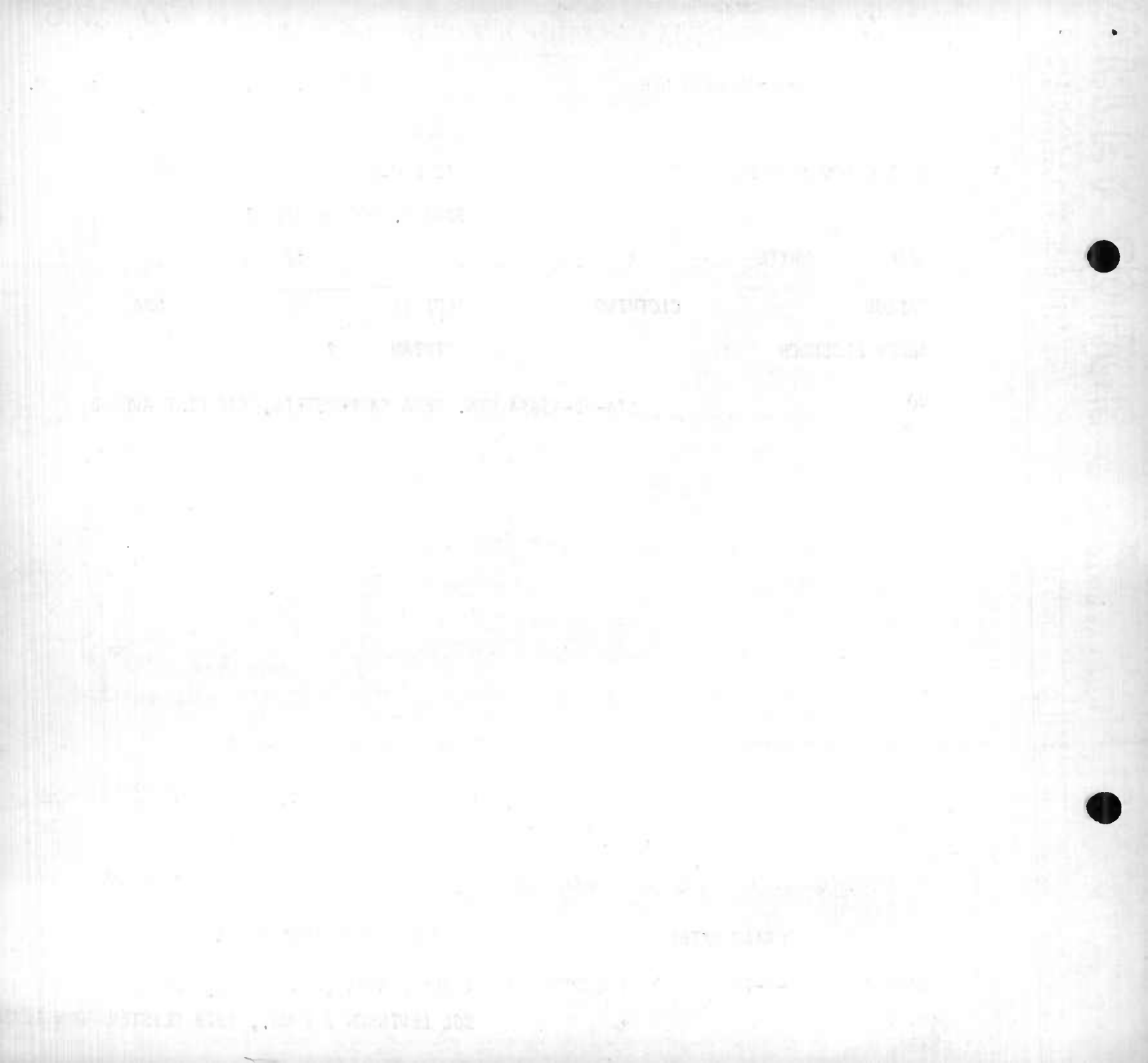
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3704	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) JOSEPH DRUTZ		2. DATE AND HOUR OF DEATH April 5, 1970 1:55 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6810 PARK HEIGHTS AVENUE, APT. 5		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 5, 1900 70	9. AGE (In years last birthday) 70	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN			10B. KIND OF BUSINESS OR INDUSTRY SELDEN COAT CO.		11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME MORRIS DRUTZ		
14. MOTHER'S MAIDEN NAME ROSE ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT OXFORD HOUSE, ADDRESS APT. 5 MRS. STELLA DRUTZ, 6810 PARK HEIGHTS AVENUE #15		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE: Anterior MI - 16 yrs ago (B) DUE TO, OR AS A CONSEQUENCE OF: Anterior myocardial infarct - 16 yrs ago (C) DUE TO, OR AS A CONSEQUENCE OF: 2nd MI - Feb. 1970					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 10/5		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 9 to 19 70 and that (I) (we) last saw the deceased alive on 4/5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 					
23A. SIGNATURE Sol Smith				23B. DATE SIGNED 4/5/70	
23C. PHYSICIAN'S NAME (Type) SOL SMITH				23D. ADDRESS 6810 PARK HEIGHTS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-6-70		24C. NAME of CEMETERY or CREMATORY RODDE ZEDEK	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 8 1970			
25B. NAME OF REGISTRAR D. E. J. J. J. J.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
E-216		70 3705		70 3705	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		NATHAN EISBRUCH		APRIL 6, 1970 5:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JEWISH CONVALESCENT HOME			A. STATE MARYLAND		
			B. COUNTY		
C. CITY OR TOWN BALTIMORE			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3006 W. ROGERS AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) AUSTRIA	
13. FATHER'S NAME ABBEY EISBRUCH			14. MOTHER'S MAIDEN NAME MIRIAM ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-32-6565A		17. INFORMANT MRS. REBA SAPPERSTEIN, 5500 GIST AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septisemia (B) DUE TO, OR AS A CONSEQUENCE OF: Acute & chronic urinary tract infection (C) DUE TO, OR AS A CONSEQUENCE OF: Obstructive uropathy		
19. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe cerebral arteriosclerosis & decubitus ulcer		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from JAN 19 1969 to April 6 1970, that (1) (we) last saw the deceased alive on 4-6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Gerald Oster MD			23B. DATE SIGNED 4-7-70		
23C. PHYSICIAN'S NAME (Type) GERALD OSTER			23D. ADDRESS 6812 REISTERSTOWN ROAD		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-7-70		24C. NAME of CEMETERY or CREMATORY OHR KNESSETH ISRAEL ANSHE SFARD, BALTIMORE, MARYLAND	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR R. E. E.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

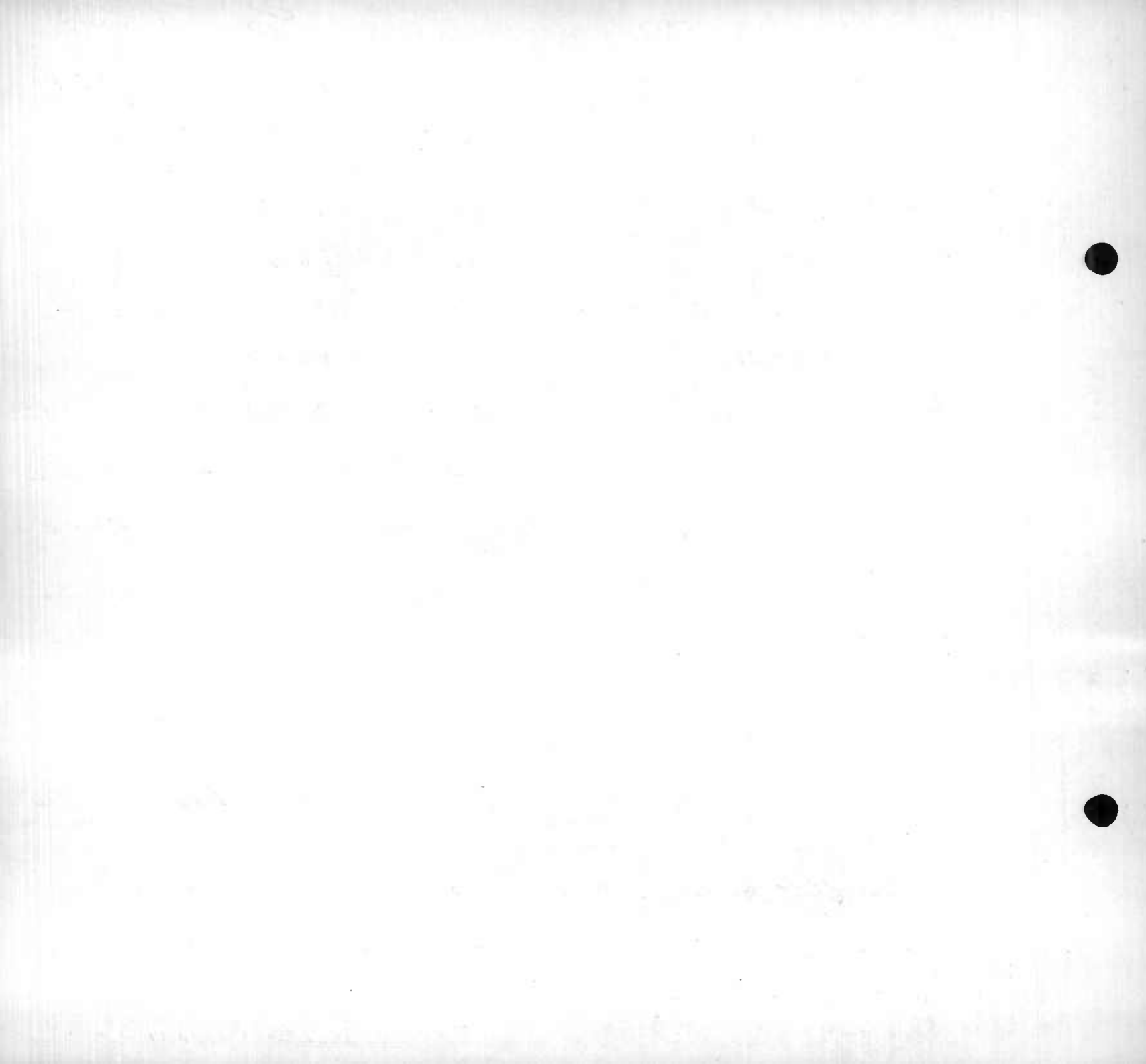
K-615 70 3706		BALTIMORE CITY HEALTH DEPARTMENT		70 3706	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Anna KREBNER</i>		2. DATE AND HOUR OF DEATH <i>4/5/70 5:50 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 House In The Pines - Bel. Ave</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Rosedale</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>7704 Brightside Ave Balto 37</i>			
5. SEX <i>Female</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 16 1892</i>	9. AGE (in years last birthday) <i>77</i>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Czechoslovakia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>Anton Srobody</i>			
14. MOTHER'S MAIDEN NAME <i>Julia ?</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			
16. SOCIAL SECURITY NO. <i>215-09-2289 B</i>		17. INFORMANT <i>Glory Dietner 7704 Brightside Ave Balto 37</i>			
18. <i>437.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Cardiovascular Accident</i> (B) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Recurrent Pneumonia Multiple Sclerosis, Recurrent Chronic Heart Disease Decubiti.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Months.</i> <i>Months.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/5/1970</i> to <i>4/5/1970</i> that (I) (we) last saw the deceased alive on <i>4/1/1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Albert B. Bradley</i>		23B. DATE SIGNED <i>4/5/70</i>		23C. PHYSICIAN'S NAME (Type) <i>ALBERT B. BRADLEY</i>	
23D. ADDRESS <i>4900 Belair Road, Balto Md.</i>		24A. BURIAL CREMATION, REMOVAL, (Specify) <i>Burial</i>			
24B. DATE <i>4/8/70</i>		24C. NAME of CEMETERY or CREMATORY <i>Bohemian National</i>		24D. LOCATION (City, town, or county) (State) <i>Balto Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 8 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Philip F. Crach 1211 Chesacone Balto 37</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3707	
B-300		70 3707		X REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mary L. Beatty</i>		2. DATE AND HOUR OF DEATH <i>4/6/70</i> <i>1:35 P.</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		5. SEX <i>Female</i> 6. RACE <i>White</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Agnes Hospital</i>		C. CITY OR TOWN <i>Arbutus</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>4311 Wilkens Ave.</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/28/02</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		9. AGE (In years lost birthday) <i>67</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hugh A. Beatty</i>		ADDRESS <i>4311 Wilkens Ave.</i>	
18. <i>431.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral hemorrhage</i> (B) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1 Jan</i> 19 <i>70</i> to <i>6 Apr</i> 19 <i>70</i> , that (I) (we) lost saw the deceased alive on <i>1 Apr</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William Goodman</i>		23B. DATE SIGNED <i>6 Apr 70</i>		23C. PHYSICIAN'S NAME (Type) <i>Dr. William Goodman</i>	
23D. ADDRESS <i>1334 Sulphur Spring Rd.</i>		23E. NAME OF REGISTRAR <i>E. E. E.</i>		23F. FUNERAL DIRECTOR <i>Ambrose E. E.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/9/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cem.</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. STATE <i>Maryland</i>		24F. ADDRESS <i>1324 Sulphur Sp. Rd.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 8 1970</i>		25B. NAME OF REGISTRAR <i>E. E. E.</i>		25C. FUNERAL DIRECTOR <i>Ambrose E. E.</i>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3708	
C-530 70 3708				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>CHENOWITH PETER E.</i>		2. DATE AND HOUR OF DEATH <i>April 5, 1970 11 PM.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 BON SECOURS HOSPITAL</i>			A. STATE <i>MARYLAND</i> B. COUNTY <i>1802</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>19 N. CAREY ST. 21223</i>		
5. SEX <i>MALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 7 1924</i>	9. AGE (In years last birthday) <i>46</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>?</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Peter Chenowith Sr.</i>			14. MOTHER'S MAIDEN NAME <i>Ryan - Mary Margaret</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i>		16. SOCIAL SECURITY NO. <i>217-14-5386</i>		17. INFORMANT ADDRESS <i>Viola M. Chenowith - 3422 Ash St.</i>	
18. <i>571.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>HEMORRHAGE</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>EMPHYSEMA - VARICES</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>CIRRHOSIS OF LIVER</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i> <i>2 some</i> <i>3 years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>ONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.]		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from <i>4.4</i> 19 <i>70</i> to <i>4.5</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>4.5.70</i> 19 <i>70</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sam Kerr MB ChB</i>				23B. DATE SIGNED <i>4-5-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>IAN C. KERR MB ChB</i>		23D. ADDRESS <i>BON SECOURS HOSP. BALTO #23</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/9/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i>	
				24D. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 8 1970</i>		25B. NAME OF REGISTRAR <i>John E. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Ann Donovan - 3818 Roland Ave.</i>	

1900-1901

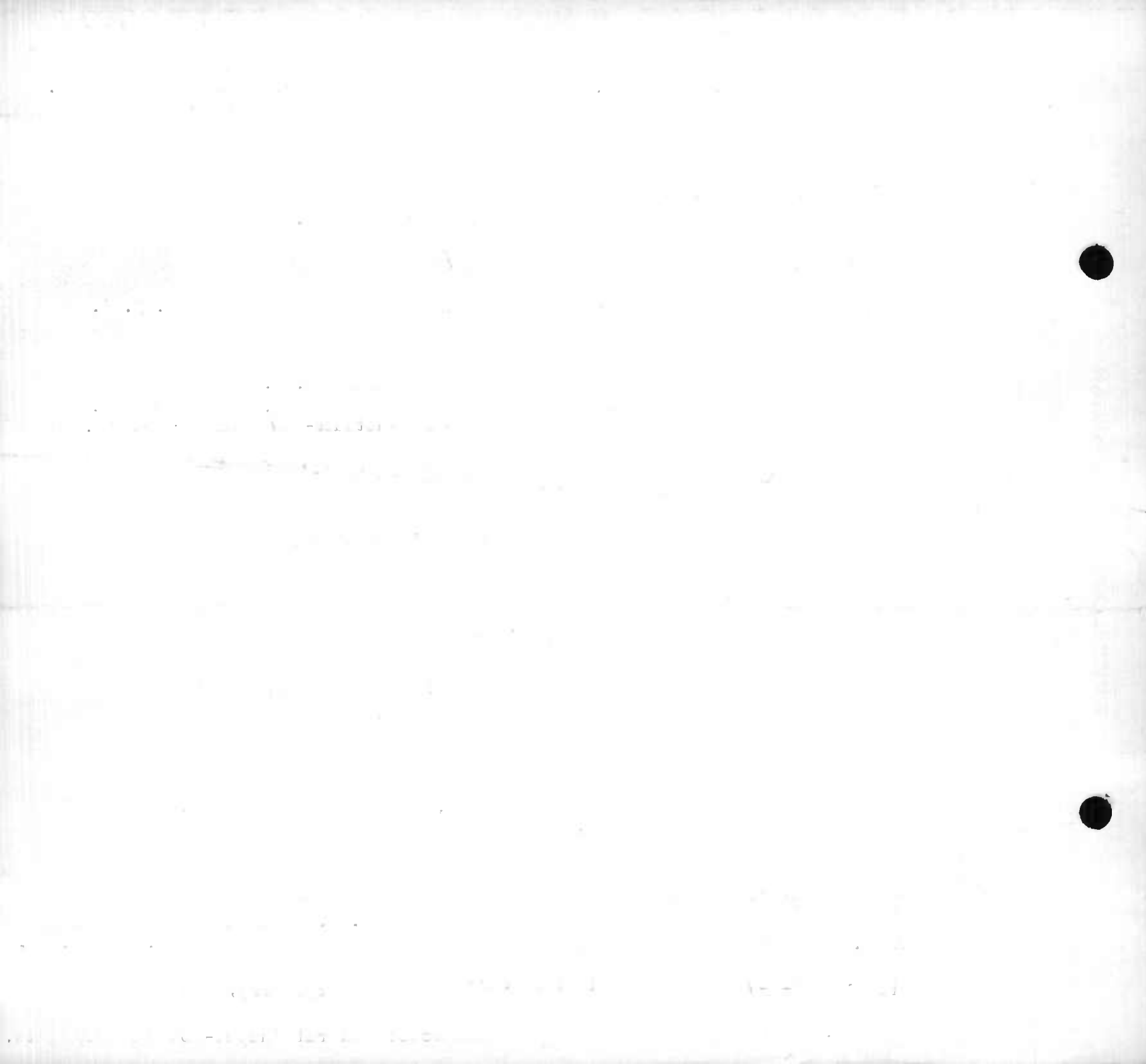
1901-1902

1902-1903

FUNERAL DIRECTOR: IMPORTANT

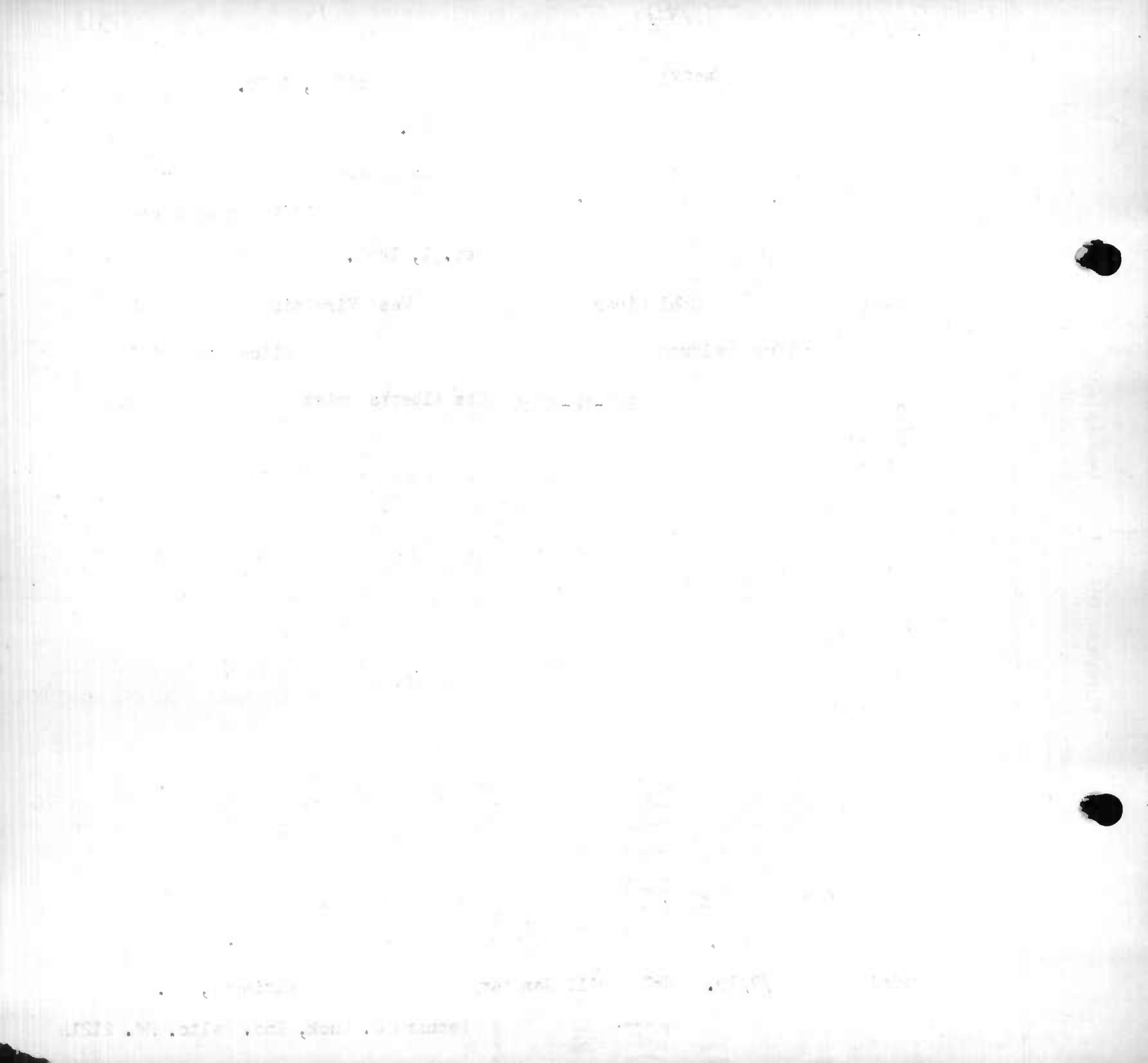
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-523 BIRTH NO.		70 3709 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		70 3709 REG. NO.	
1. NAME OF DECEASED (Type or Print) ANSTEATT, HERNARD G.			2. DATE AND HOUR OF DEATH April 5, 1970 12:45 A.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 23 3900 Loch Raven Boulevard Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4309 Norfolk Ave.		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-13	9. AGE (in years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groom		10B. KIND OF BUSINESS OR INDUSTRY Race Track	11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William Ansteatt			14. MOTHER'S MAIDEN NAME Bertha Hobine		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes 3-7-41 to 9-28-45		16. SOCIAL SECURITY NO. 077-05-8746	17. INFORMANT Records V. A. Hospital ADDRESS 3900 Loch Raven Blvd., Baltimore, Md. Thomas Ansteatt 107 Belle Grove Rd.		
18. 0111-1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis, Moderate (A) IMMEDIATE CAUSE Bilateral DUE TO, OR AS A CONSEQUENCE OF: Broncho Pneumonia Left Upper Lobe (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Fatty Liver			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fatty Liver					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (U) (this hospital) attended the deceased from April 2, 1970 to April 5, 1970 that (U) (we) last saw the deceased alive on April 5, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (U) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John M. Jackson, MD				23B. DATE SIGNED 5 April 1970	
23C. PHYSICIAN'S NAME (Type) JEAN M. JACKSON MD		23D. ADDRESS V. A. Hospital 3900 Loch Raven Blvd., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-9-70	24C. NAME of CEMETERY or CREMATORY Hopewell Cemetery		24D. LOCATION (City, town, or county) (State) Montgomery, Ohio	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS Armacost Funeral Chapel-4600 Liberty Hgts.	



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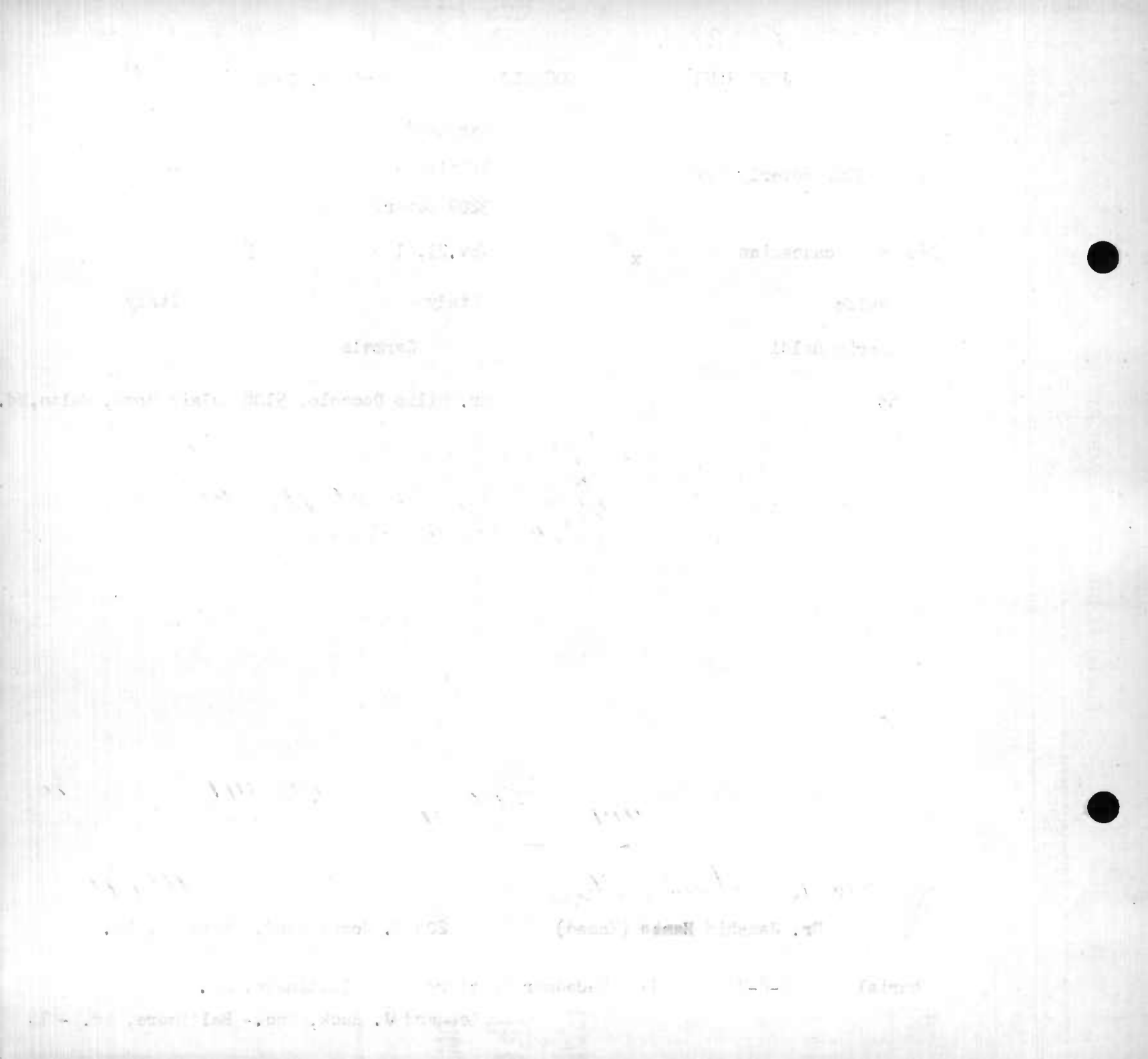
W-436		70 3710		BALTIMORE CITY DEPARTMENT		REG. NO. 70 3710	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Carl (Hazy) Waldron				2. DATE AND HOUR OF DEATH April 3, 1970. 1:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 House in The Pines 2525 W. Belvedere Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2636			
5. SEX M		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 1, 1889.	
9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alfred Waldron				14. MOTHER'S MAIDEN NAME Alice Shepard			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 232-12-3219		17. INFORMANT Mrs Alberta Poist		ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia Diabetes Anticoagulation				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo. 10 yr.?			
19. DATE OF OPERATION				20A. AUTOPSY? (Yes or No) No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED			
21F. HOW DID INJURY OCCUR?				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22. I certify that (I) (this hospital) attended the deceased from Feb 9 1970 to April 3 1970, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23B. DATE SIGNED 4/6/70			
23A. SIGNATURE Lester N. Kolman				23C. PHYSICIAN'S NAME (Type) Lester N. Kolman			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/7/70.			
24C. NAME of CEMETERY or CREMATORY Holly Hill Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970				25B. NAME OF REGISTRAR Robert E. Taylor, Md.			
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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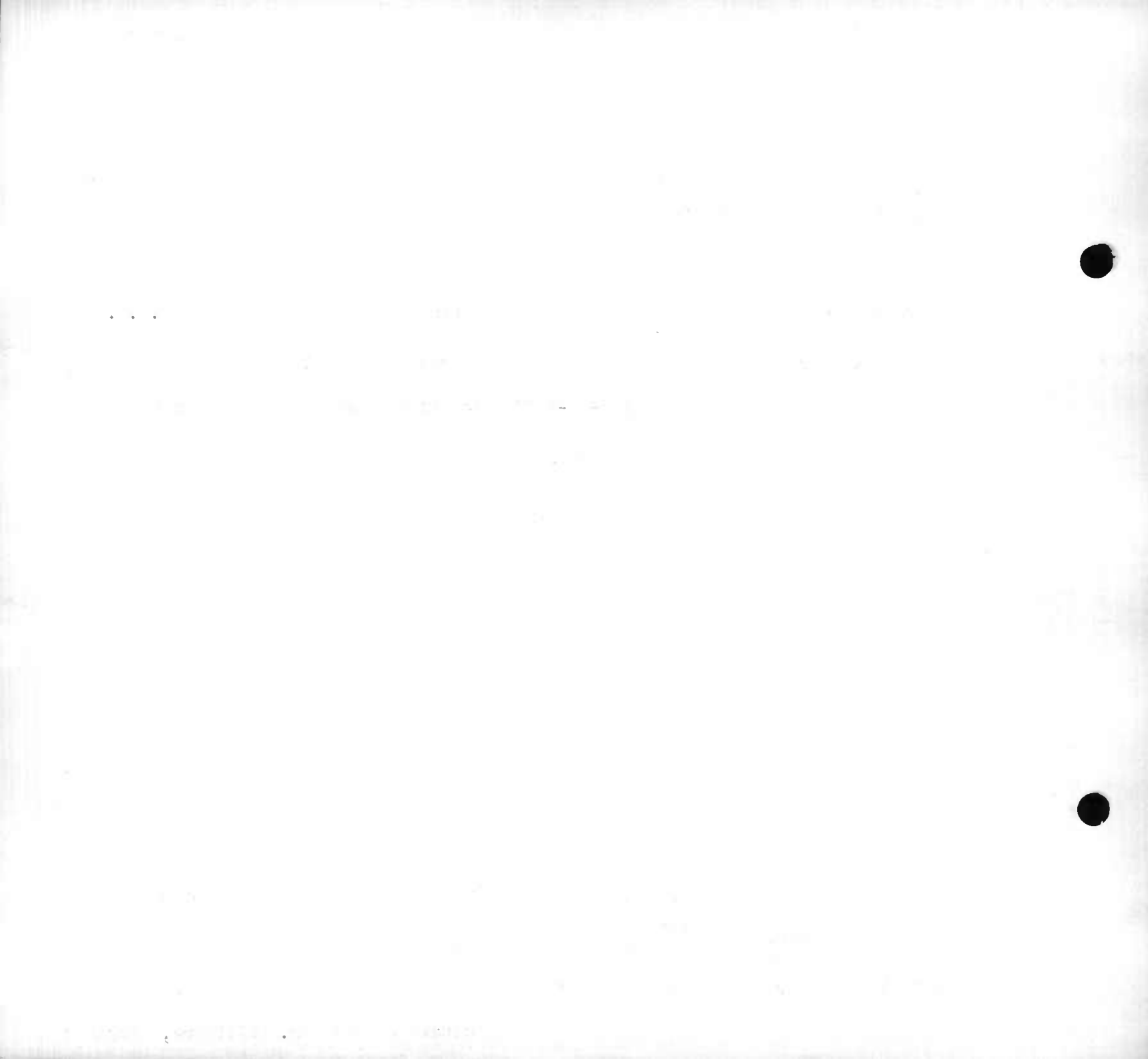
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.		70 3711	
BIRTH NO.		D-240 70 3711		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		JOSEPHINE DOCCOLO		2. DATE AND HOUR OF DEATH		April 5, 1970 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
00 3202 Beverly Road				Maryland		2731	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3202 Beverly Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
female	caucasian	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 21, 1884	85			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
housewife				Italy		Italy	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Mario Baldi				Carmela			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no				Mr. Philip Doccolo, 5108 Belair Road, Balto, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		I Massive Cerebral hemorrhage					
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		2. Arteriosclerotic Heart disease					
		(B) Broncho pneumonia					
		(C) _____					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 2/4 19 67 to 4/6 19 70, that (I) (we) last saw the deceased alive on 4/4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Dr. Jamshid Hamed (Hamed)						4/6/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Jamshid Hamed (Hamed)				204 E. Jopps Road, Towson 4, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
burial		4-8-70		Holy Redeemer Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 8 1970		Robert E. Taylor		Leonard J. Ruck, Inc. - Baltimore, Md. - 14			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. <u>44-70-3712</u>	
S-352 70 3712		CERTIFICATE OF DEATH			
BIRTH NO. <u>70 3712</u>		1. NAME OF DECEASED (Type or Print) <u>FANNIE R STANKIEWICZ</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>APRIL 6, 1970 1:01 P.M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>EDGEWOOD NURSING HOME 6000 BELLONA AVE.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>MD CO.</u> 5200			
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <u>606 RITA DR.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		8. DATE OF BIRTH <u>8-23-07</u> 9. AGE (in years last birthday) <u>62</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Roma</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>382-09-1702</u>		14. MOTHER'S MAIDEN NAME <u>Grace ?</u>	
17. INFORMANT <u>Mrs Linda Zeleznik</u>		ADDRESS <u>Same</u>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>1. 174 X I METASTATIC CARCINOMA TO BRAIN</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMATOSIS DUE TO CARCINOMA OF BREAST</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA OF BREAST</u>			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1968</u> to <u>4/6</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>GEORGE G. FINNEY JR.</u>				23B. DATE SIGNED <u>4/6/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>George G. Finney Jr.</u>				23D. ADDRESS <u>5820 York Rd</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/9/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 8 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Faber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J Ruck Inc. Baltimore, Maryland</u>			



FUNERAL DIRECTOR: IMPORTANT

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W-256 70 3713		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3713	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WAGNER; ELMER W.		4/7/1970 2 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MD-General Hospital 48		A. STATE MD.			
		B. COUNTY 21206		2631	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4202 Glenarm Ave			
5. SEX M	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-7-03	9. AGE (in years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUTUAL CLERK		10B. KIND OF BUSINESS OR INDUSTRY RACE TRACKS		11. BIRTHPLACE (State or foreign country) Baltimore, MD	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Julien Wagner		14. MOTHER'S MAIDEN NAME Mary Preston			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 212-05-2435		17. INFORMANT Lucile Wagner (The same)	
18. CAUSE OF DEATH 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Emphysema, diabetes, A.S.-H-D		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Failure Pulmonary Embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3-28-70 to 4-7-70 that (1) (we) last saw the deceased alive on 4/6/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Fateh		23B. DATE SIGNED 4/7/70			
23C. PHYSICIAN'S NAME (Type) M. Fateh		23D. ADDRESS MD-Gen. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/10/70		24C. NAME of CEMETERY or CREMATORY MORELAND MEM. CEM.	
24D. LOCATION BALTIMORE, MD.					
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Robert E. Vanden...		25C. FUNERAL DIRECTOR LEONARD J. Ruck, Inc. 21214	



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SHIRLEY CALDERONE

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

6024 Amberwood Rd. Apt. A1

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

4

5

1970

7 P.

M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Sept. 8, 1934.

10. AGE (In years last birthday)

35

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

USA

E. STREET AND NUMBER

6024 Amberwood Rd. Apt. A1

13. FATHER'S NAME

?

McCutcheon

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Theresa Snyder

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mr. Joseph Calderone, 2031 E. Belverdere Ave.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Placidyl poisoning
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A.

DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A.

EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
home

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

6024 Amberwood Rd. Apt. A1

22D. TIME OF INJURY (APPROX.)

4-5-70

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject ingested overdose.

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/8/70.

24C. NAME OF CEMETERY or CREMATORY

Moreland Memorial Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 8 1970

25B. NAME OF REGISTRAR

R. E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, Inc. Balto. Md. 21214

McIntosh

New York

Honolulu

Mr. Joseph McIntosh, 2022 N. Broadway Ave.

Walter - General Secretary

Partial

Leonard A. Smith, 2nd, 2nd, 2nd

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3715

BIRTH NO.

1. NAME OF DECEASED DELOIS
(Type or Print)DOLORES BARNETT2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

3. DATE PRONOUNCED DEAD Month Day Year Hour
April 6, 1970 10:30 P.M.

FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

1635 Gorsuch Avenue 4-22-70A. STATE Maryland B. COUNTY 907

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Female

Negro

WIDOWED ☐ DIVORCED ☐

Baltimore

YES ☒ NO ☐

9. DATE OF BIRTH

10. AGE (In years last birthday)

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

SEPT 7 - 4623

E. STREET AND NUMBER

1635 Gorsuch Avenue

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF

13. FATHER'S NAME

QUENBURG Co. VaWHAT COUNTRY?Edward Hurt

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Homemakerat HomeOzella BRADB

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT Edward Hurt RED 11 PM 1970 ADDRESS 1635 MEHEARRIN VA19. E 965 X 1

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Multiple gunshot wounds

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Home1635 Gorsuch Avenue

22D. TIME (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

4-6-70 10:26 P. m.WHILE AT WORK ☐NOT WHILE AT WORK ☒Shot during altercation

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

Deputy

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐4/7/70

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

TEMPORAL4/7/70Family PlotQUENBURG Co Va

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

APR 8 1970Robert E. Spitz, M.D.J.P. Lowry - KENNESAW Va

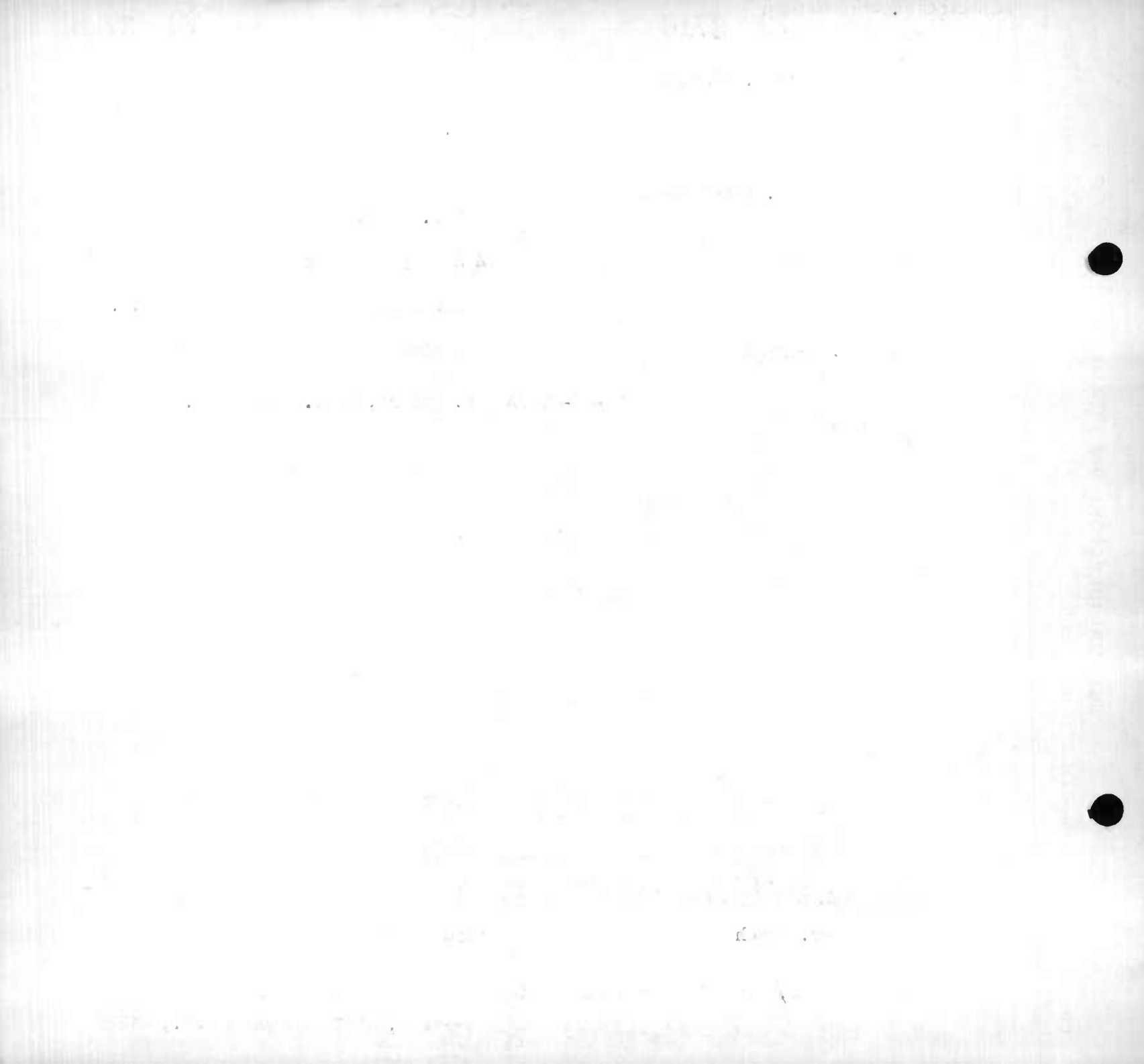
Letter from M.E.'s office

4-22-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3716	
B-625 70 3716		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Alma E. Bergund			2. DATE AND HOUR OF DEATH 4/6/70		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 22 S. Athol Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2834		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 22 S. Athol Avenue		
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/1885	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME C arl H. Bergund			14. MOTHER'S MAIDEN NAME Louise		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-10-4727A		17. INFORMANT ADDRESS Mr. Tyler , 22 St Athol Ave. 21229	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction - 1 day</p> <p>(B) ANTERIOR CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CV Disease 57 yrs.</p> <p>(C) _____</p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> </div> <div style="width: 50%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/4 19 70 to 4/5 19 70 , that (I) (we) last saw the deceased alive on 4/3/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas E. Roach M.D.				23B. DATE SIGNED 4/7/70	
23C. PHYSICIAN'S NAME (Type) Dr. Roach				23D. ADDRESS 5550 Baltimore National Pike	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/8/70		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave., 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3717	
F-236 BIRTH NO. 1. NAME OF DECEASED (Type or Print) John Joe Foster		CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH Apr. 6, 1970 8:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 99 Union Memorial Hospital (DOA)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 2864 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4615 Manordene Road			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/22/1893	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pur. Agent		10B. KIND OF BUSINESS OR INDUSTRY Gen'l Elec Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown			
16. SOCIAL SECURITY NO. 215-09-8732		17. INFORMANT Miss Emma Schott, 306 E. 32nd Street.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Carcinoma of Pancreas (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Arteriosclerotic Cardio-vascular Disease		Several Years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Mar. 5 1970 to April 6 1970 , that (I) (we) last saw the deceased alive on April 4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (did not) view the body after death.					
23A. SIGNATURE Dr. Lloyd Zimmermann M.D.				23B. DATE SIGNED 4/7/70	
23C. PHYSICIAN'S NAME (Type) Dr Lloyd Zimmermann				23D. ADDRESS 3202 Harford road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/9/70		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 8 1970 25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			
25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229				ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3718	
BIRTH NO. H-553 70 3718 1. NAME OF DECEASED (Type or Print) Hammonds Baby Boy		CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH 4-3-70 11:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital of Maryland 38		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1925 Hillside Drive			
5. SEX MALE	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-30-70	9. AGE (In years last birthday) 0	If Under 1 Yr. Months 3 Days 2 Hours 2 Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ray Hammonds			
14. MOTHER'S MAIDEN NAME Barbara Ruth Henry		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Ray Hammonds ADDRESS 21207 1925 Hillside Drive, Balto. Md			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Cardiorespiratory failure DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES (B) Respiratory distress syndrome DUE TO, OR AS A CONSEQUENCE OF: (C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-30 19 70 to 4-3 19 70 that (I) (we) last saw the deceased alive on 4-3 19 70 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE BALG				23B. DATE SIGNED 4-3-70	
23C. PHYSICIAN'S NAME (Type) BALG DEGREE				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-6-1970		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 8 1970			
25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR WITZKE ADDRESS 4101 Edmondson Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

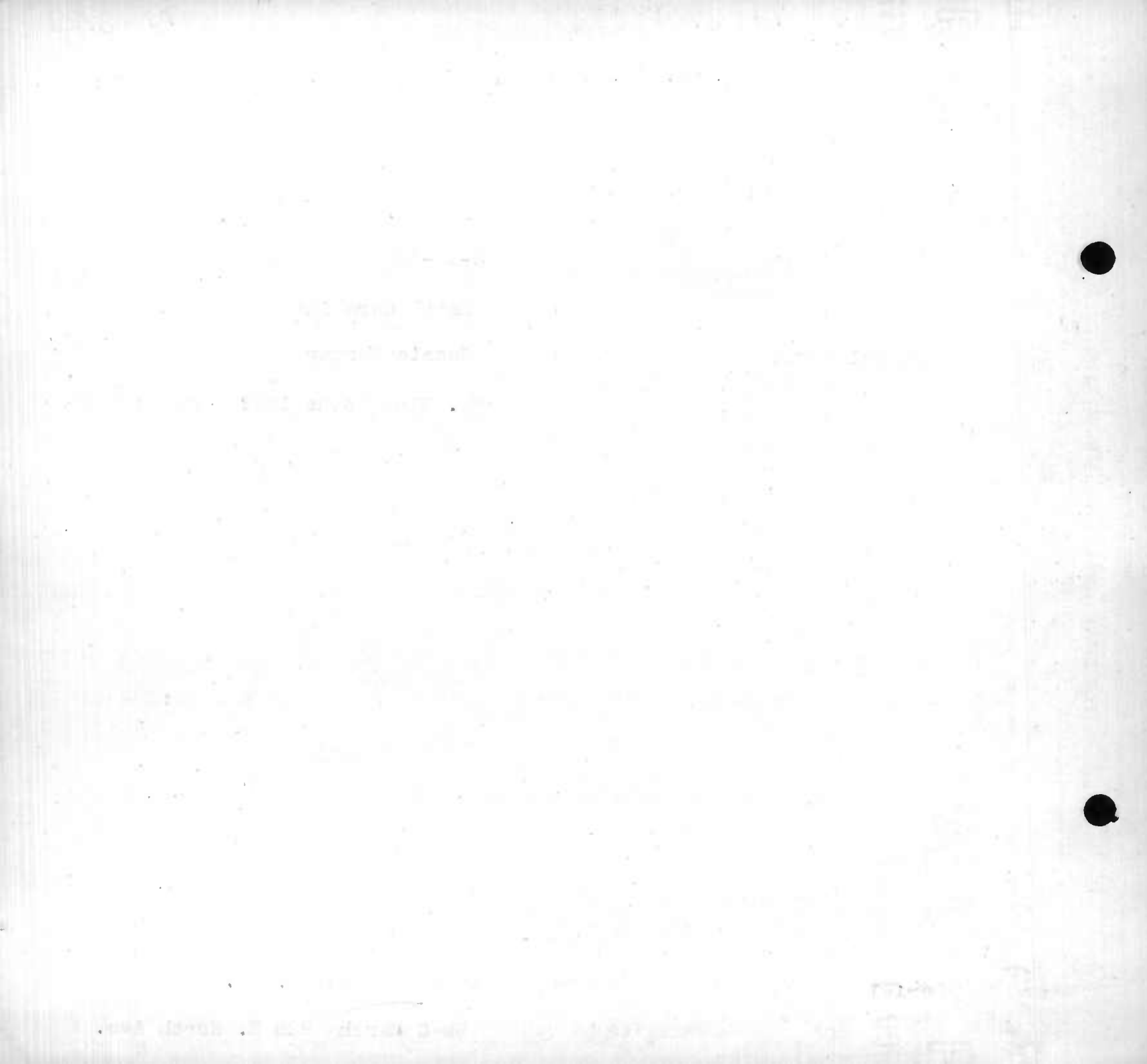
BALTIMORE CITY HEALTH DEPARTMENT				70 3719	
CERTIFICATE OF DEATH				REG. NO. 70 3719	
BIRTH NO. <u>2220</u>		1. NAME OF DECEASED (Type or Print) <u>MR. WARREN ZIEGAUS</u>			
2. DATE AND HOUR OF DEATH <u>APRIL 6, 1970 6:55 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>MARYLAND GENERAL HOSPITAL</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u>			
C. CITY OR TOWN <u>BALTIMORE 21201</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>701 CATHEDRAL ST.</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-1-10</u>	9. AGE (in years last birthday) <u>60</u>	If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACQUISITION</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ENCK PRATT LIBRARY</u>		11. BIRTHPLACE (State or foreign country) <u>Tacoma, Washington</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>IRVIN WARREN ZIEGAUS</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN ALICE ROE MOON</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN W.W. II</u>			
16. SOCIAL SECURITY NO. <u>538-28-0753</u>		17. INFORMANT <u>Mrs. George Z. Hubble, daughter</u> ADDRESS <u>3115 S. 5010 Goodnow Rd. Baltimore Md. 21206</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>SKULL FRACTURE</u>		19. CAUSE OF DEATH (Immediate Cause) <u>RUPTURED ABDOMINAL AORTIC ANEURYSM</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>	
20. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.) <u>II</u>		21. DUE TO, OR AS A CONSEQUENCE OF: <u>RUPTURED ABDOMINAL AORTIC ANEURYSM</u>		<u>< 24 Hrs.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>4-6-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RUPTURED ABD. ANEURYSM</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner RELEASED BY ME)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>STREET</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>400 CATHEDRAL ST.</u>	
21D. TIME OF INJURY (APPROX.) <u>APRIL 6 1970 11AM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>FELL AFTER RUPTURE OF AORTIC ANEURYSM</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 6, 1970</u> to <u>APRIL 6, 1970</u> that (I) (we) last saw the deceased alive on <u>APRIL 6, 1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles S. Harrison, M.D.</u>				23B. DATE SIGNED <u>4-7-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES S. HARRISON. M.D.</u>				23D. ADDRESS <u>Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation April 8, 1970 Greenmount</u>		24B. DATE <u>APR 8 1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION (City, town, or county) <u>Baltimore Md.</u>		24E. STATE (State) <u>Baltimore Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 8 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC</u>	
25D. ADDRESS <u>Baltimore Md.</u>					

SECRET

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3720	
K-263 70 3720				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		XXXXXX RICHARDSON, Myrtle		2. DATE AND HOUR OF DEATH 04-05-70 9:00P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 804		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1207 N. BRADFORD ST.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-19	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Lemuel Boone			14. MOTHER'S MAIDEN NAME Gussie Morgan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Elmo Boone 1352 Stonewood Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 038.8 I CAUSE OF DEATH SEPTIC SHOCK (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BACTERIAL SEPSIS, SITE UNKNOWN 24 HR (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR 24 HR		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 4/5 1970 to 4/5 1970, that (I) (we) last saw the deceased alive on 4/5/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D.			23B. DATE SIGNED 4/5/70		
23C. PHYSICIAN'S NAME (Type) MICHAEL J. PREECE M.D.			23D. ADDRESS JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/9/70		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR E. J. Taylor		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3721

BIRTH NO.

1. NAME OF DECEASED (Type or Print) M. EVELON GRAHAM				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 4 5 70 9:20 P.M.			
6. SEX Female				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5-11-43				10. AGE (In years lost birthday) 26		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME William D. Graham			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				15. MOTHER'S MAIDEN NAME Beatrice Norris			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO. 219-38-4287		18. INFORMANT ADDRESS Beatrice Graham 1732 McKean Street	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE Drowning DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1732 McKean Ave.				22D. TIME (Month) (Day) (Year) (Hour) (Minute) (Approx.) 4 5 70 8:53 P.M.			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Subj. found with head in tub of water			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-6-70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/9/70		24C. NAME of CEMETERY or CREMATORY Arbutus Mem Park		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970				25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.	

3-11-70

Meeting

CLARENCE-ADAM-REYNOLDS-DAVIDSON-JACK-ROBERTSON-EDWARD

WILLIAMSON-ROBERTSON

WILLIAMSON-ROBERTSON

2000

1000

Shelton

10/10

10/10

10/10

10/10

10/10

VALLEY RIVER
VALLEY FORD
2000-1000

1

70 3722

BALTIMORE CITY HEALTH DEPARTMENT

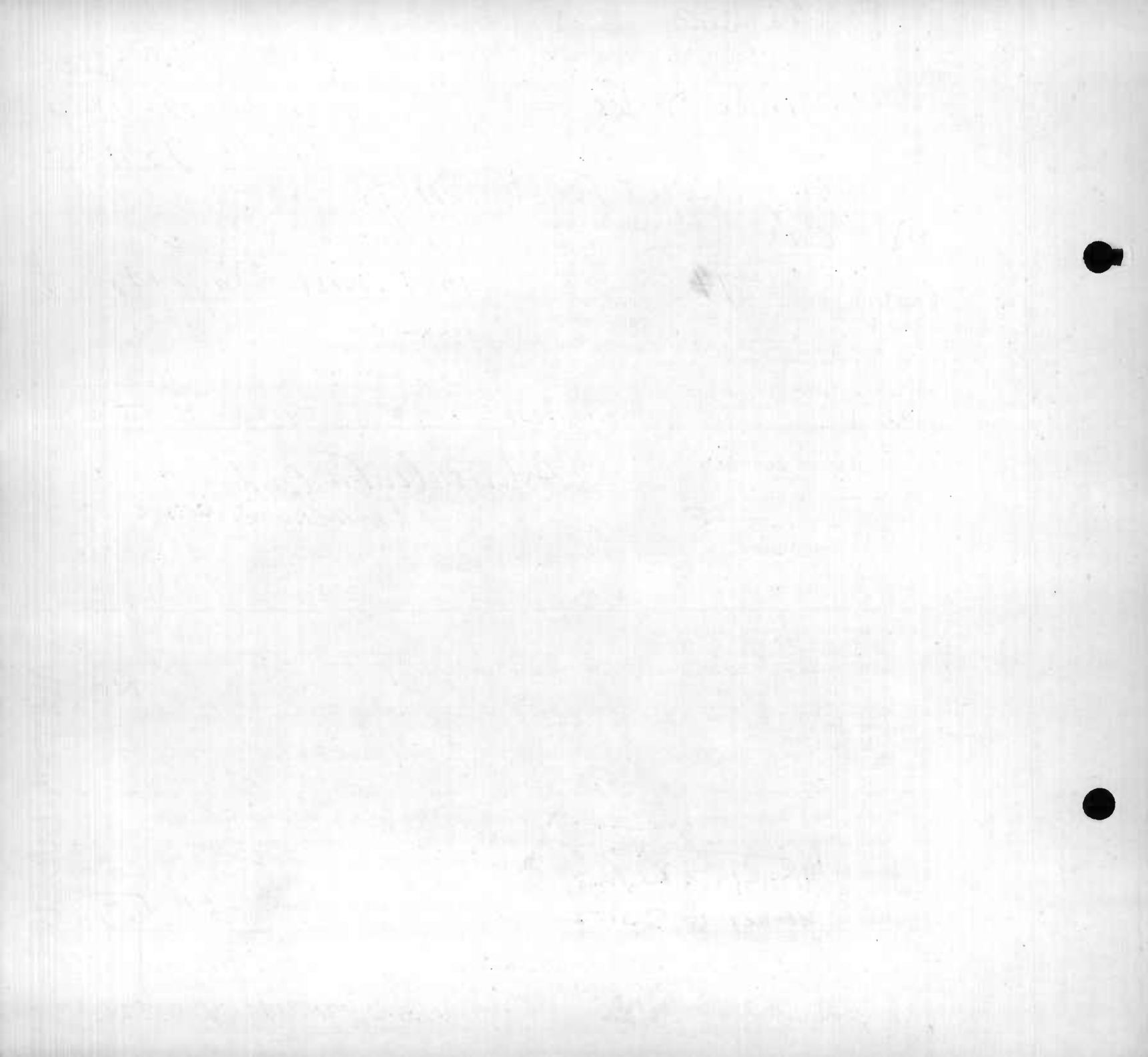
D-200

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. _____ REG. NO. 70 3722

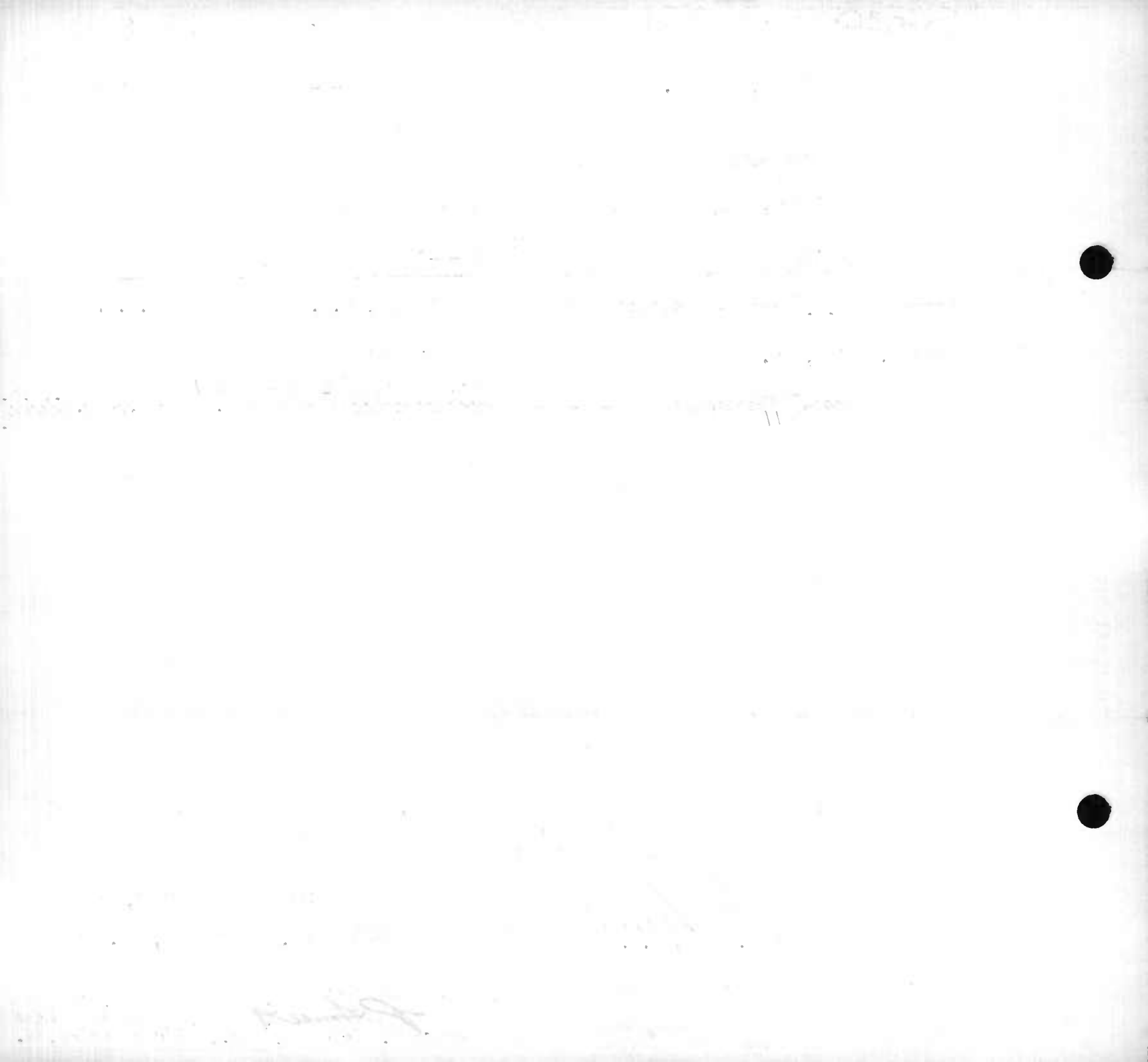
1. NAME OF DECEASED (Type or Print) <u>Jerome (Dicks) DIX</u>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input checked="" type="checkbox"/> <u>4</u> <u>4</u> <u>70</u> <u>12:30</u> P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>00 1901 W. Fayette St</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <u>4</u> <u>4</u> <u>70</u> <u>12:30</u> P.M.	
6. SEX <u>M</u>		7. RACE <u>col</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u>	
9. DATE OF BIRTH <u>12/25/95</u>		10. AGE (In years, months, days, hours, minutes) <u>74</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>717-09-8351</u>	
15. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		18. INFORMANT <u>Elizabeth Dix</u>	
19. <u>412.41</u>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arterio-sclerotic Cardiovascular Disease.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION <u>6</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Werner W. Spitz</u>		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Werner W. Spitz</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/10/70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 8 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>WMC MARCH</u>		ADDRESS <u>928 E North Ave</u>	

VS 151-REV. 1/1/68



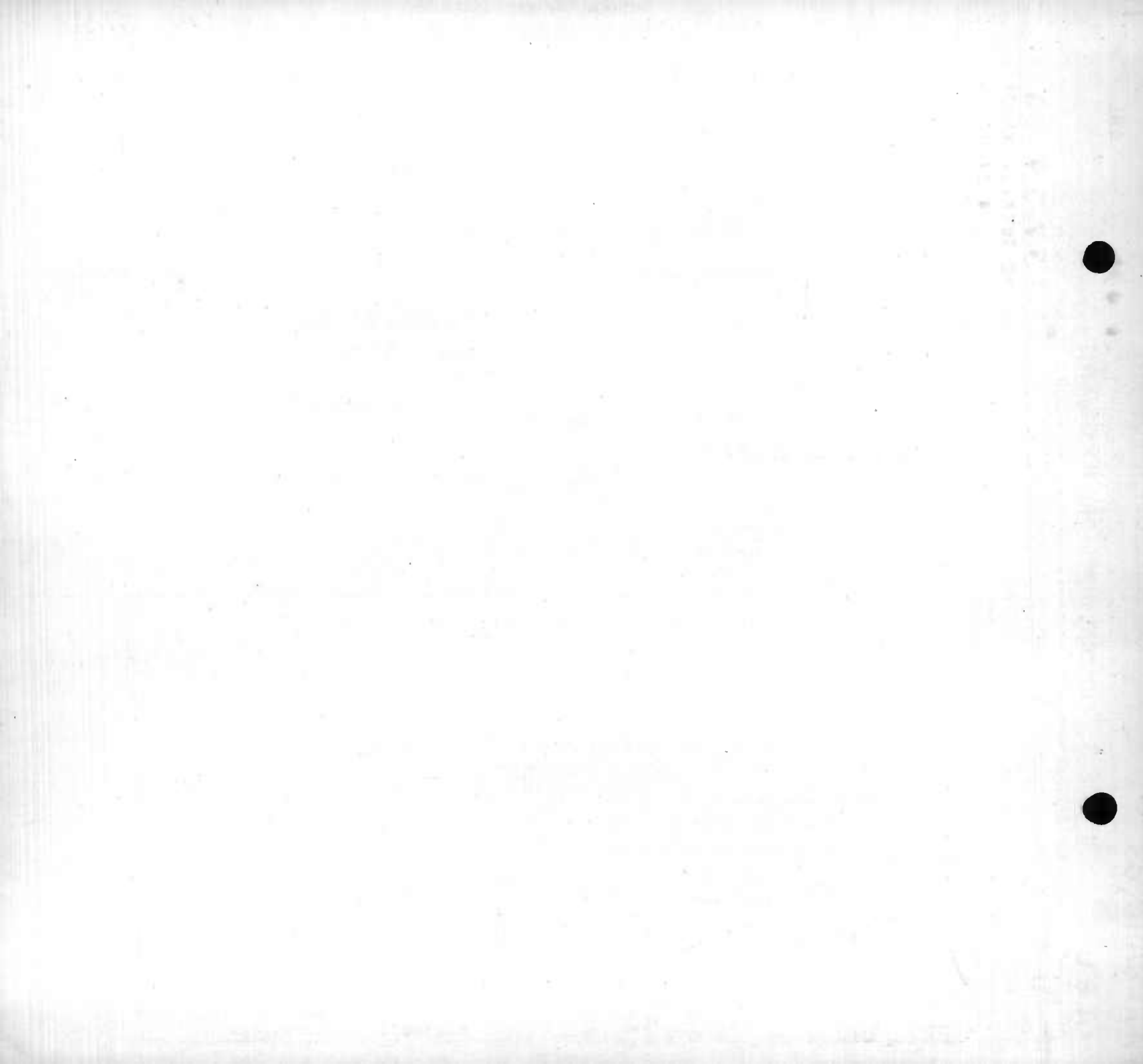
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530 70 3723		BALTIMORE CITY HEALTH DEPARTMENT		70 3723	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) SMITH, CARL H.		2. DATE AND HOUR OF DEATH 4-1-70 12:35 A			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218		6. CITY OR TOWN Baltimore		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. STREET AND NUMBER 1 Willow Avenue		9. STREET AND NUMBER 1 Willow Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-26	9. AGE (In years last birthday) 43	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper U.S. Weather Bureau		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Carl H. Smith, Sr.		14. MOTHER'S MAIDEN NAME Cecelia Olive	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 579-28-13-86		17. INFORMANT Olive Chaisson - Sister 701 Rosemere Ave. S.S.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE Lymphoma DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from March 30, 19 70 to April 1, 19 70 that (H) (we) last saw the deceased alive on April 1, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) YOUNG E. CHUN, M.D.	
23D. ADDRESS		23E. ADDRESS		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/4/70		24C. NAME OF CEMETERY OR CREMATORY Washington National Cemetery	
24D. LOCATION (City, town, or county) Suitland, Prince George, Maryland		24E. LOCATION (City, town, or county) Silver Spring, Md.		24F. LOCATION (City, town, or county)	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

APR 8 1970
VS 150-REV. 1/1/68



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3725

BIRTH NO.

1. NAME OF DECEASED

(Type in full)

Alton Diggs

2. DATE OF DEATH

Known ☐Estimated ☒

Month

Day

Year

Hour

Min.

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

Min.

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38 University Hosp.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years last birthday)

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.)

(Day) (Month) (Year)

(Hour) (Min.)

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner W. Spitz

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4.5.70

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

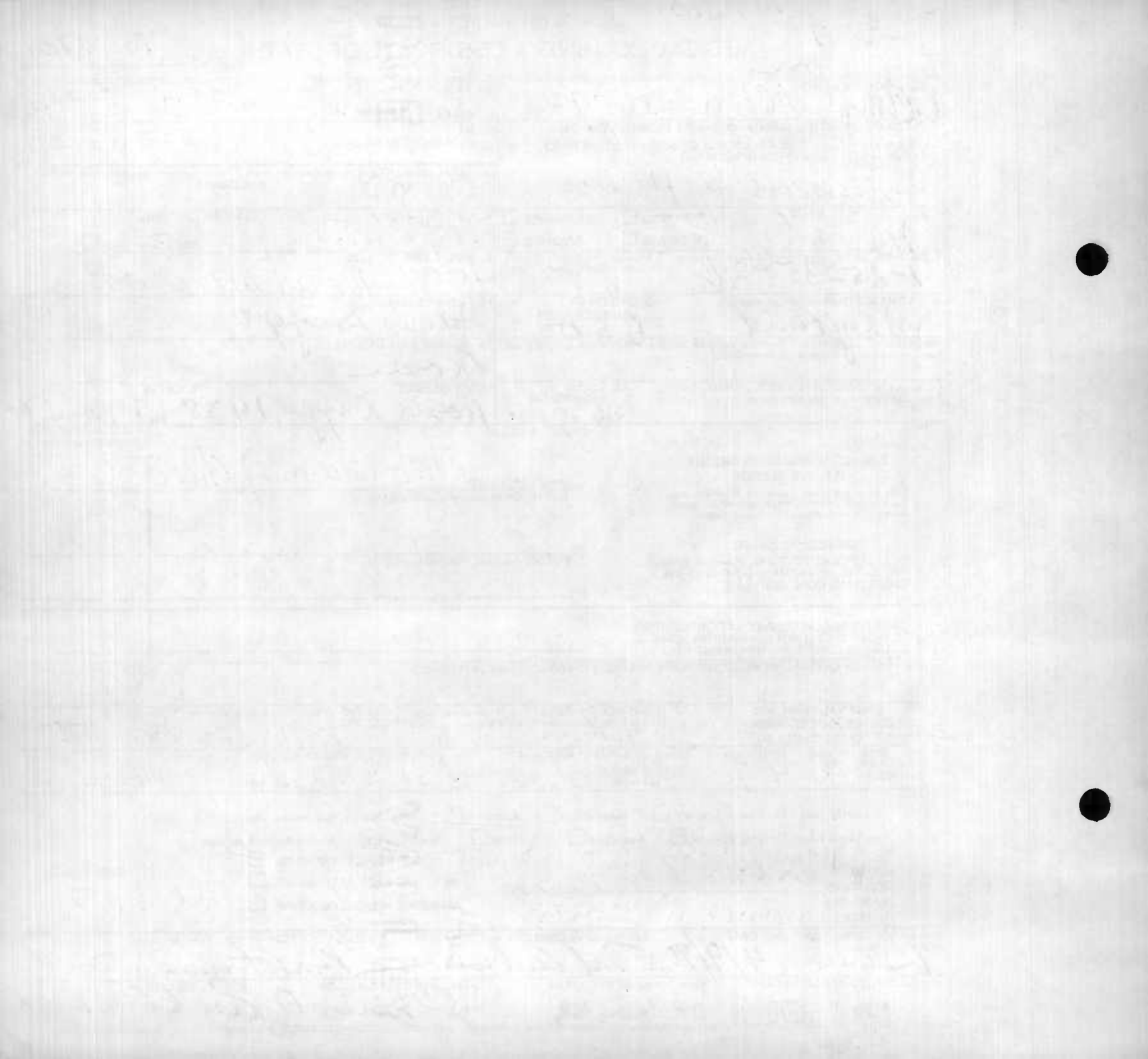
25C. FUNERAL DIRECTOR

ADDRESS

APR 8 1970

Robert E. Fisher, M.D.

Charles A. Rice 661 W. Borne



D-52570

3726

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3726

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RANDOLPH DUNCAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 2 70 7:17 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001105 E. North Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour April 2 1970 7:17 p.m.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10-29-49		10. AGE (In years last birthday) 20	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Orce Duncan		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 909	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Pauline Laton		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 219-52-6701		18. INFORMANT Susan Ann Duncan 3928 Flowerton Rd.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1105 E. North Ave. 909		22D. TIME OF INJURY (APPROX.) 4 2 70 6:40p	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Unknown	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/3/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-6-70	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

ACADEMIC BOND

FOR THE YEAR 1900

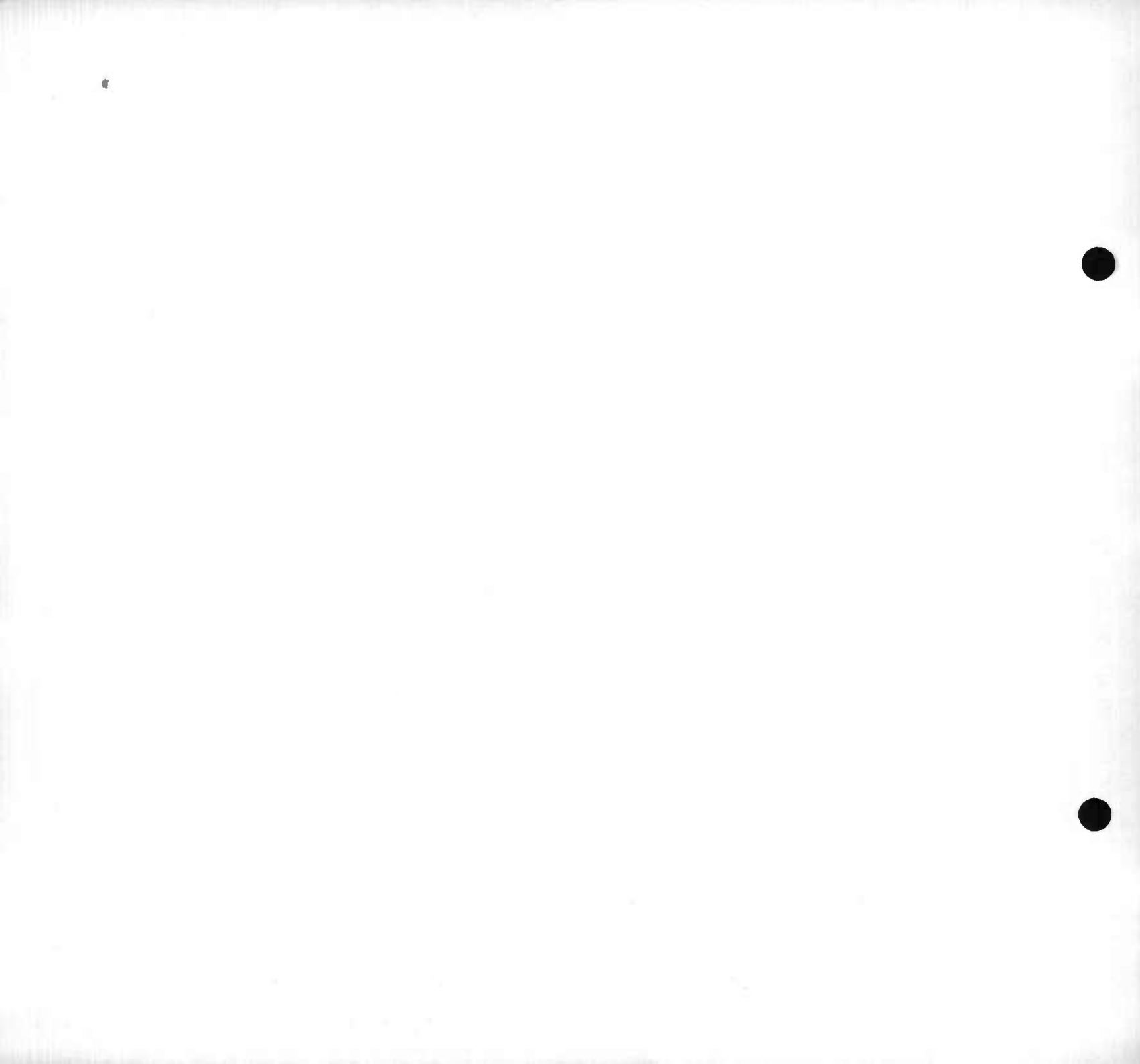
1900

22

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3727	
BIRTH NO. 70 3727		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RALPH A. POWELL		2. DATE AND HOUR OF DEATH 6 April 1970 2 04 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University of Maryland Hospital		A. STATE MD.		B. COUNTY 1302	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 3/5/15		9. AGE (in years last birthday) 55		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Elba		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. —		17. INFORMANT Chas	
18. 395791		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Renal Failure		36 hrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF:		10 Days	
		(C) Aortic Insufficiency		6 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 25 19 70 to April 6 19 70 that (I) (we) last saw the deceased alive on April 5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mark M. Applefeld, MD		23B. DATE SIGNED April 6, 1970		23C. PHYSICIAN'S NAME (Type) MARK M. APPLEFELD, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/70		24C. NAME OF CEMETERY OR CREMATORY MT Auburn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Adolphus Halstead	
25D. LOCATION (City, town, or county) (State) Baltimore MD		25E. ADDRESS 1206 W North Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

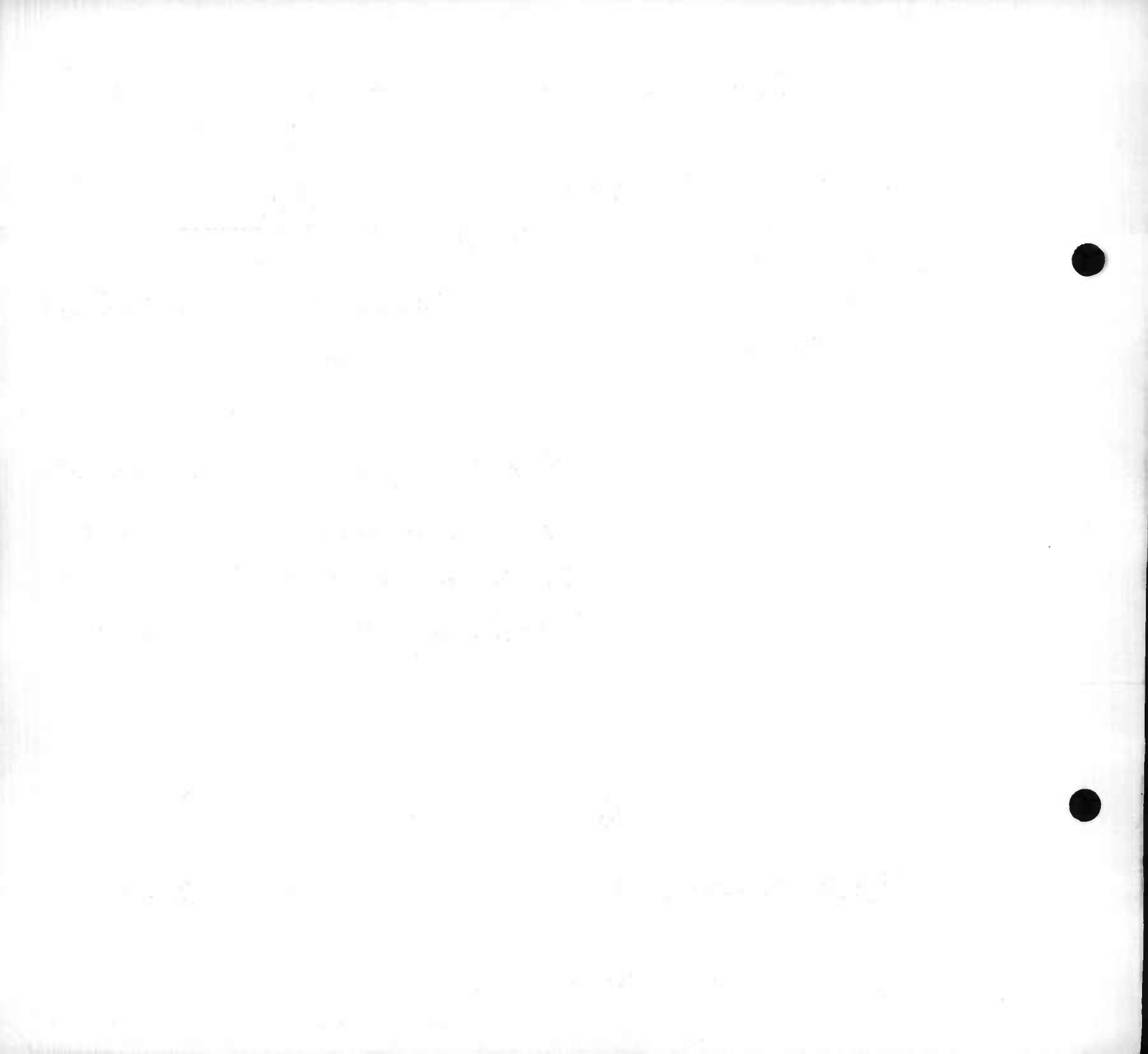
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3728	
D-355 70 3728		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		Ella C. Diedeman		2. DATE AND HOUR OF DEATH April 6, 1970 12:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutions: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
00 4901 Crowson Avenue		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-20-1895 9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Samuel Bayne		14. MOTHER'S MAIDEN NAME Ella Kellum		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-12-0230		17. INFORMANT ADDRESS Road Mrs. William A. Feustle 1414 E. Joppa	
18. 4/10/9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction		10 minutes	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic vascular disease		10 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Sept 30 19 68 to Feb 19 19 70		that (1) (we) last saw the deceased alive on Feb 19 19 70 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Samuel I. O'Mansky		23B. DATE SIGNED April 8 1970			
23C. PHYSICIAN'S NAME (Type) Dr. Samuel I. O'Mansky		23D. ADDRESS 8523 Loch Raven Blvd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-9-70		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	
24D. LOCATION Pikesville, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Robert E. Jenkins, Jr.	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Road Balto., Md.		21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 3729	
BIRTH NO. M-200 70 3729				1. NAME OF DECEASED (Type or Print) JOHN E. MACKAY JR.		2. DATE AND HOUR OF DEATH April 5, 1970 4:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md. B. COUNTY Baltimore		C. CITY OR TOWN 5300	
Univ. of Maryland Hosp.		38		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER Owings Mills	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/7/45	9. AGE (in years last birthday) 24	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN Mackay		14. MOTHER'S MAIDEN NAME Unknown Maude M. Mackay		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Rosewood State Hosp. Owings Mills				(A) IMMEDIATE CAUSE Respiratory - Cardiac Arrest		26 HRS	
				(B) ULL PNEUMONIA		? 50 HRS	
				(C) SEVERE MENTAL RETARDATION		24 YEARS	
				? malabsorption		2 mos.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 3 19 70 to April 5 19 70 that (I) (we) last saw the deceased alive on April 5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Charles L. Cromwell				23B. DATE SIGNED 4/5/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/8/70		24C. NAME OF CEMETERY or CREMATORY Loudon PK. Cem.		24D. LOCATION Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR E. S. MacNeil		ADDRESS 301 Frederick Rd Baltimore	



FUNERAL DIRECTOR: IMPORTANT

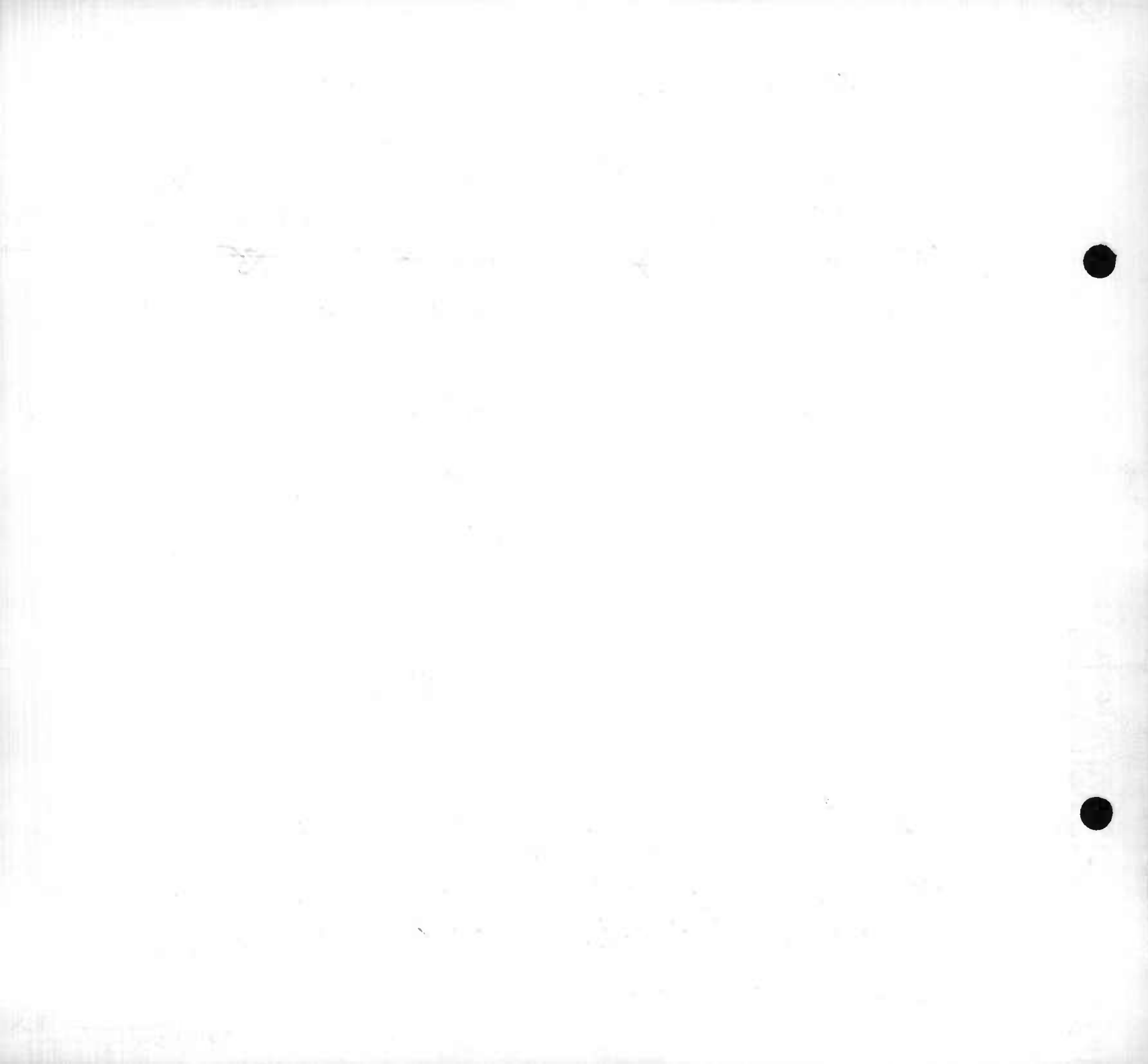
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department		REG. NO. 70 3730	
BIRTH NO. 13-620 70 3730		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Etta Barrash		2. DATE AND HOUR OF DEATH April 6, 1970 9:10 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Good Samaritan Hospital 5601 Loch Raven Boulevard Baltimore, Maryland 21212		A. STATE Maryland B. COUNTY 21215 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3410 Bancroft Rd.			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-9-1895
9. AGE (In years last birthday) 74		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Merkel		14. MOTHER'S MAIDEN NAME Esther R. Ruth	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212326186B	
17. INFORMANT Evelyn Barrash		ADDRESS 3410 Bancroft Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 436.9 I (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac and Resp arrest (B) left Cerebro Vascular Accident DUE TO, OR AS A CONSEQUENCE OF: (C) Arteriosclerotic C.V. Disease	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED /	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? /
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) /	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) /	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) /	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) /	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> /	21F. HOW DID INJURY OCCUR? /	
22. I certify that (I) (this hospital) attended the deceased from Jan 26 1970 to April 6 1970 , that (I) (we) last saw the deceased alive on April 6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE H. Semerdjian M.D.		23B. DATE SIGNED April 6 1970	
23C. PHYSICIAN'S NAME (Type) Grant Semerdjian M.D.		23D. ADDRESS Johns Hopkins Hosp - Balto 21205	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/6/70	24C. NAME OF CEMETERY OR CREMATORY Morgan Alsham	24D. LOCATION (City, town, or county) (State) Balto Md
25A. DATE REC'D BY HEALTH DEPT. APR 8 1970		25B. NAME OF REGISTRAR Phyllis E. Taylor	
25C. FUNERAL DIRECTOR Sydney Lewis		ADDRESS 9610 Reisterstown Rd	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

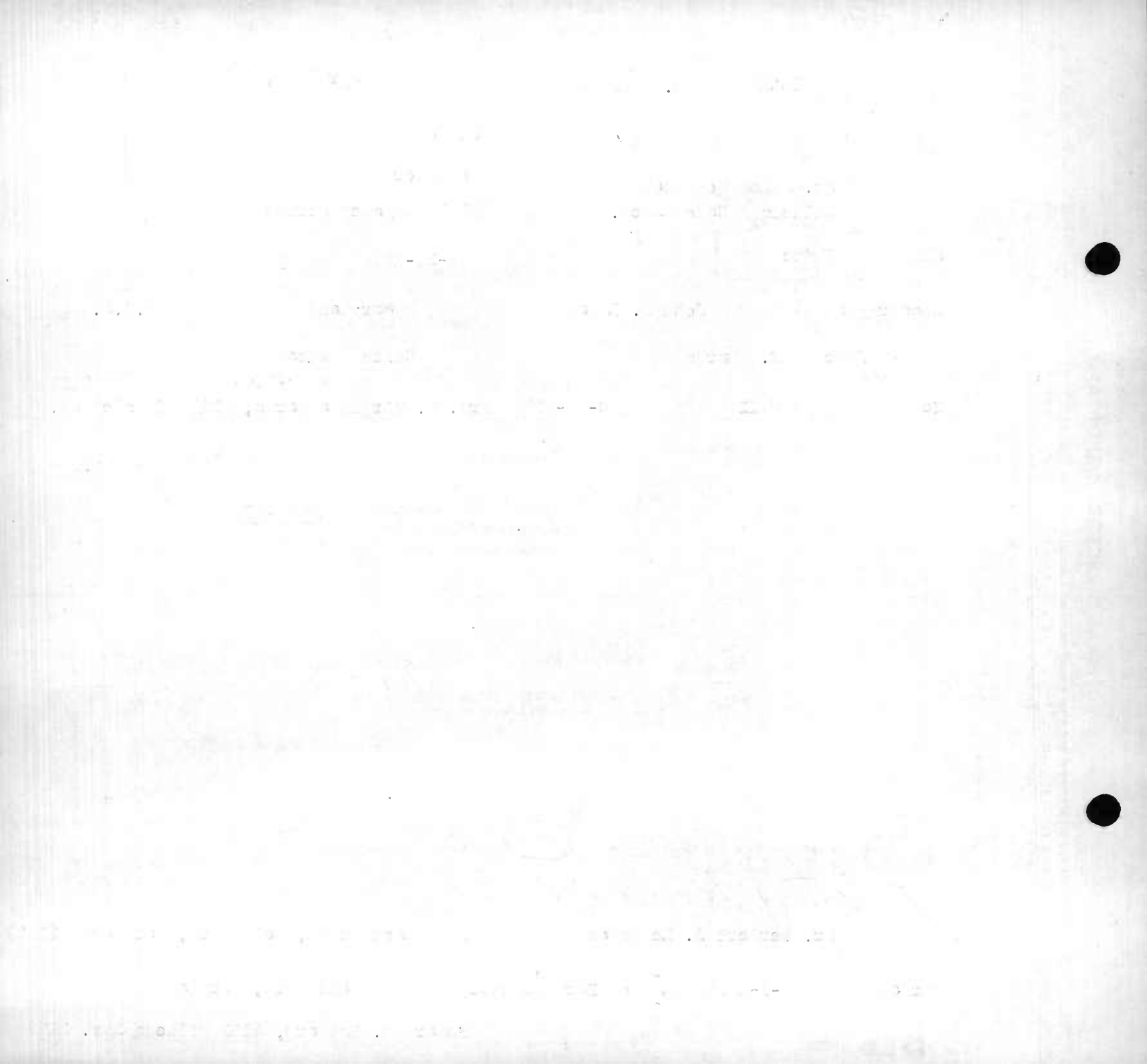
BIRTH NO. <u>G-616</u> <u>70</u> <u>3731</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70</u> <u>3731</u>	
1. NAME OF DECEASED (Type or Print) <u>MAX GERBER</u>			2. DATE AND HOUR OF DEATH <u>7 April 1970</u> <u>7:00</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Levinthal Hebrew Home and Infirmary</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>2717</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Balta</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>GreenSpring & Belton Avenues</u>		
5. SEX <u>Male</u>	6. RACE <u>CAUC</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1875</u>	9. AGE (In years last birthday) <u>95</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Israel</u>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Melvin Gerber</u>	
18. <u>712.4 I</u>		CAUSE OF DEATH		ADDRESS <u>Old Court Rd</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrhythmia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>years.</u>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>31 Mar</u> 19 <u>69</u> to <u>7 April</u> 19 <u>70</u> . that (we) last saw the deceased alive on <u>7 April</u> 19 <u>70</u> and that (we) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>Morris Ostroff, MD</u>				23B. DATE SIGNED <u>7 April 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>MORRIS OSTROFF, MD</u>				23D. ADDRESS <u>Levinthal Hebrew Home & Infirmary</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/8/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Men</u>	
24D. LOCATION <u>Balta</u>		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 8 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Stephen S. Lewis</u>	
25D. ADDRESS <u>9610 Reisterstown Rd</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3732	
BIRTH NO. 70 3732		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILLIAM E. MARKS			2. DATE AND HOUR OF DEATH April 6, 1970 4¹⁰ A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2006		
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Wilkins & Caton Aves.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 3217 Kingsley Street					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-1919	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10B. KIND OF BUSINESS OR INDUSTRY John D. Lucas		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph F. Marks			14. MOTHER'S MAIDEN NAME Edith Wheat		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II			16. SOCIAL SECURITY NO. 160-18-1778		17. INFORMANT Mrs. M. Virginia Marks, 3217 Kingsley St.
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Recurrent coronary thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic CVD			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/28 19 69 to 4/6 19 70 , that (I) (we) lost saw the deceased alive on 3/24 19 70 and that in 6 (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert J. Levickas, M.D.			23B. DATE SIGNED 4/7/70		23C. PHYSICIAN'S NAME (Type) Dr. Herbert J. Levickas
23D. ADDRESS 5404 East Drive, Baltimore, Maryland 21227					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-9-1970	24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkins Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> M-65270 3734 BALTIMORE CITY HEALTH DEPARTMENT 70 3734 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. _____	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <u>William Frederick MEHRING</u>	
2. DATE AND HOUR OF DEATH <u>4/5/70</u> <u>18.30</u> P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Univ. of Md. Hospital</u>	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>5600</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ. of Md. Hospital</u>	
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-9-28</u> 9. AGE (in years last birthday) <u>41</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCKING CO. - owner + operator</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Mehring</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Lookingbill</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>318-37-4851</u> 17. INFORMANT <u>Hospital Record</u> ADDRESS _____	
18. <u>430.01</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PONTINE HEMORRHAGE</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>BASILAR ANEURYSM RUPTURE?</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>HYPERTENSION</u> <u>GLOMERULONEPHRITIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
19A. DATE OF OPERATION <u>4/30/70</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>3/20/70</u> 19 <u>70</u> to <u>4/5</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/5</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Andrew M. Doyle</u>		23B. DATE SIGNED <u>4/5/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ANDREW M. DOYLE</u>		23D. ADDRESS <u>UNIVERSITY OF MARYLAND HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/8/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>United Church of Christ Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Taneytown Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 8 1970</u>		25B. NAME OF REGISTRAR <u>James E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>James E. Taylor</u>		ADDRESS <u>BRIDGE MD</u>	



M-635

70

3735

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

3735

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BERNIE MARTIN

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

00 Rear yard - 1021 N. Gay St.

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

11/26/1933

10. AGE (In years
last birthday)

16

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1007 McDonough St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Bernie Martin

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Clouise Jones

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Clouise Martin 1007 McDonough St.

19.

E8821

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Cervical spine injury
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

wall

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

rear yard - 1021 N. Gay St.

22D. TIME
OF INJURY
(APPROX.)

4-6-70

(Month) (Day) (Year) (Hour)

A. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subj. jumped from top of car to wall and

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ fell off.
and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/10/70

24C. NAME OF CEMETERY or CREMATORY

Balto. National Cem.

24D. LOCATION (City, town, or county)

5501 Frederick Ave. Rd.

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

APR 8 1970

25B. NAME OF REGISTRAR

E. Fisher, M.D.

25C. FUNERAL DIRECTOR

John L. Clifton - 1129 N. Caroline St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3736	
BIRTH NO. 8-625		70 3736		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Julius E. Brockington			2. DATE AND HOUR OF DEATH 4-6-70 2:49 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital 43			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2562 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1008 Shellbanks Rd.		
5. SEX M	6. RACE N C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-30 9. AGE (In years last birthday) 39 10. BIRTHPLACE (State or foreign country) Maryland, Balt. 11. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tow Operator			10B. KIND OF BUSINESS OR INDUSTRY —		
13. FATHER'S NAME Edward Brockington			14. MOTHER'S MAIDEN NAME Sadie Spicer		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO. 215-24-0095		
17. INFORMANT Mrs. Viola Compher			ADDRESS 1219 Slater Rd		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 303.21 Liver Failure Hepatic Coma			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic + Acute Alcoholism (B) _____ (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —		
19A. DATE OF OPERATION 4-6-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Liver Biopsy		20A. AUTOPSY? (Yes or No) Liver Biopsy	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (1) (this hospital) attended the deceased from 3-27-70 to 4-6-70 and that (I) (we) last saw the deceased alive on 4-6-70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel M. Howell MD				23B. DATE SIGNED 4-6-70	
23C. PHYSICIAN'S NAME (Type) Daniel M. Howell				23D. ADDRESS South Balt. Gen Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/70		24C. NAME OF CEMETERY OR CREMATORY Balt. Nat'l Cem.	
24D. LOCATION (City, town, or county) (State) Balt. Md		25A. DATE REC'D BY HEALTH DEPT. APR 9 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Morton E. Dyett F.H.			
25D. ADDRESS 1701 Laurens St		25E. ADDRESS —			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
S-530		70		3737		70 3737	
1. NAME OF DECEASED (Type or Print) SMITH, LUESEDA				2. DATE AND HOUR OF DEATH 4-1-70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY CARROLL			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MD.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN MARIOTTVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F		6. RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-24-03	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		9. AGE (In years last birthday) 67		11. BIRTHPLACE (State or foreign country) VA.	
13. FATHER'S NAME James Roberts				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-32-2483		17. INFORMANT Mr. Bigie Smith	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 1-5-79 I				CAUSE OF DEATH (A) IMMEDIATE CAUSE Carcinoma of Pancreas DUE TO, OR AS A CONSEQUENCE OF: With Metastases.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks.	
19. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-25-1970 to 4-1-1970 , that (I) (we) last saw the deceased alive on 4-1-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 4-1-70			
23C. PHYSICIAN'S NAME (Type) DR. Y. BABURAO				23D. ADDRESS LUTHERAN HOSPITAL, BALTO			
24A. BURIAL CREMATION, REMOVAL (specify) Burial		24B. DATE 4-4-70		24C. NAME of CEMETERY or CREMATORY Evergreen Cemetery		24D. LOCATION (City, town, or county) (State) Finksburg Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Harry Haight		ADDRESS Sylva, Md.	

1. THE NEW HOSPITALS

MARKET VALUE NO.

1-10-13

No.

U.S.A.

NO. 33-2481

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3739

BIRTH NO.

REG. NO.

1. NAME OF DECEASED
(Type or Print)

Willie DAVISON

2. DATE
OF
DEATHKnown ☐
Estimated ☒Month
4Day
4Year
70Hour
5:30

P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

003028 Walbrook Ave

3. DATE
PRONOUNCED DEADMonth
4Day
4Year
70Hour
5:45

P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD

B. COUNTY

1506

6. SEX

M

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

6 / / 1910

10. AGE In years

59

If Under 1 Yr. II Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3028 Walbrook Ave

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Smiley Davison

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Construction

15. MOTHER'S MAIDEN NAME

Maybe Syelder

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

418-01-6352

18. INFORMANT

ADDRESS

Mrs. Eva McMillian 3028 Walbrook Avenue

19. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:Fatty alteration of
Liver(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, public bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

deputy
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4. 5. 70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/8/70

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 9 1970

25B. NAME OF REGISTRAR

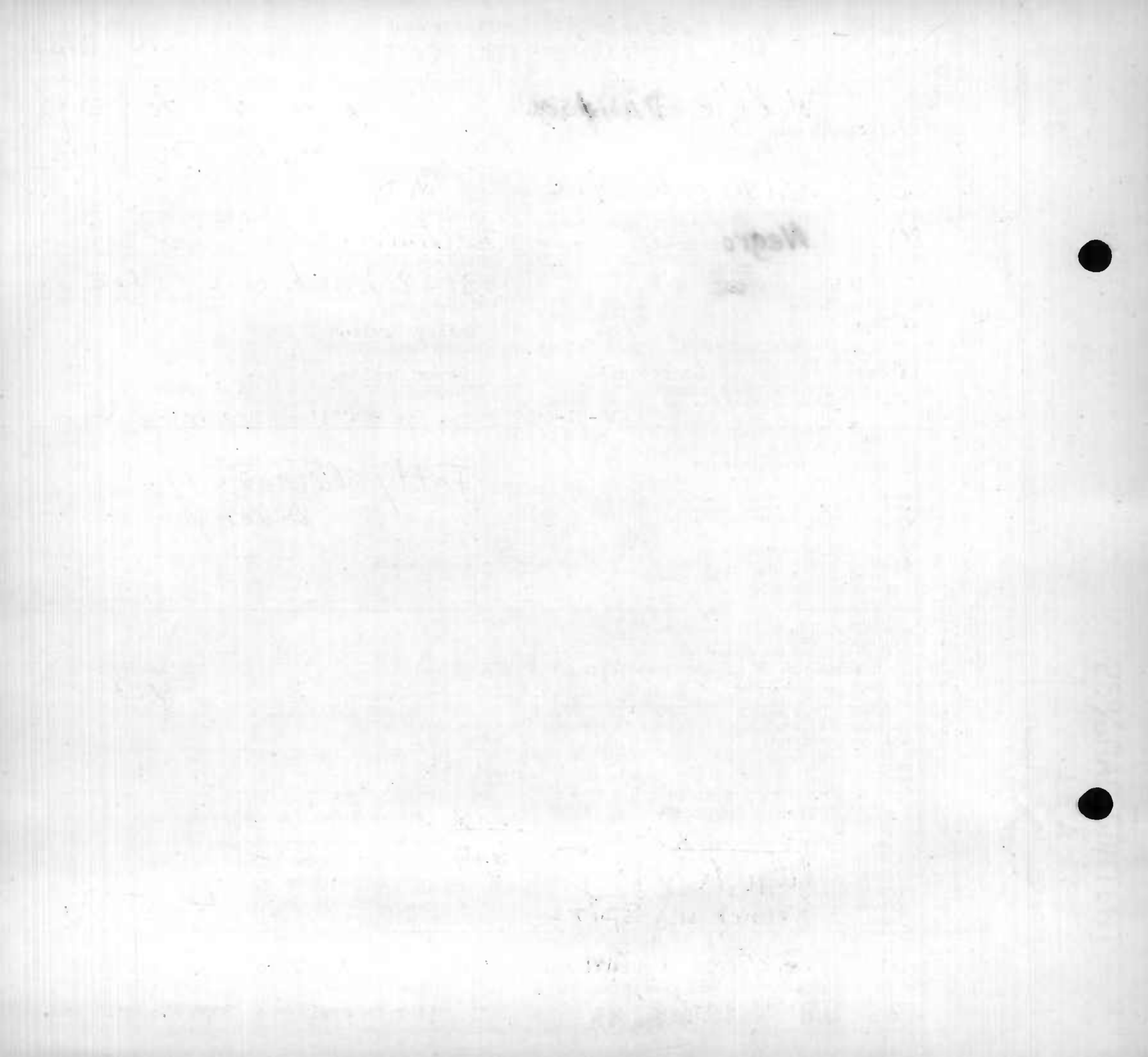
Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Nutter Funeral Home

ADDRESS

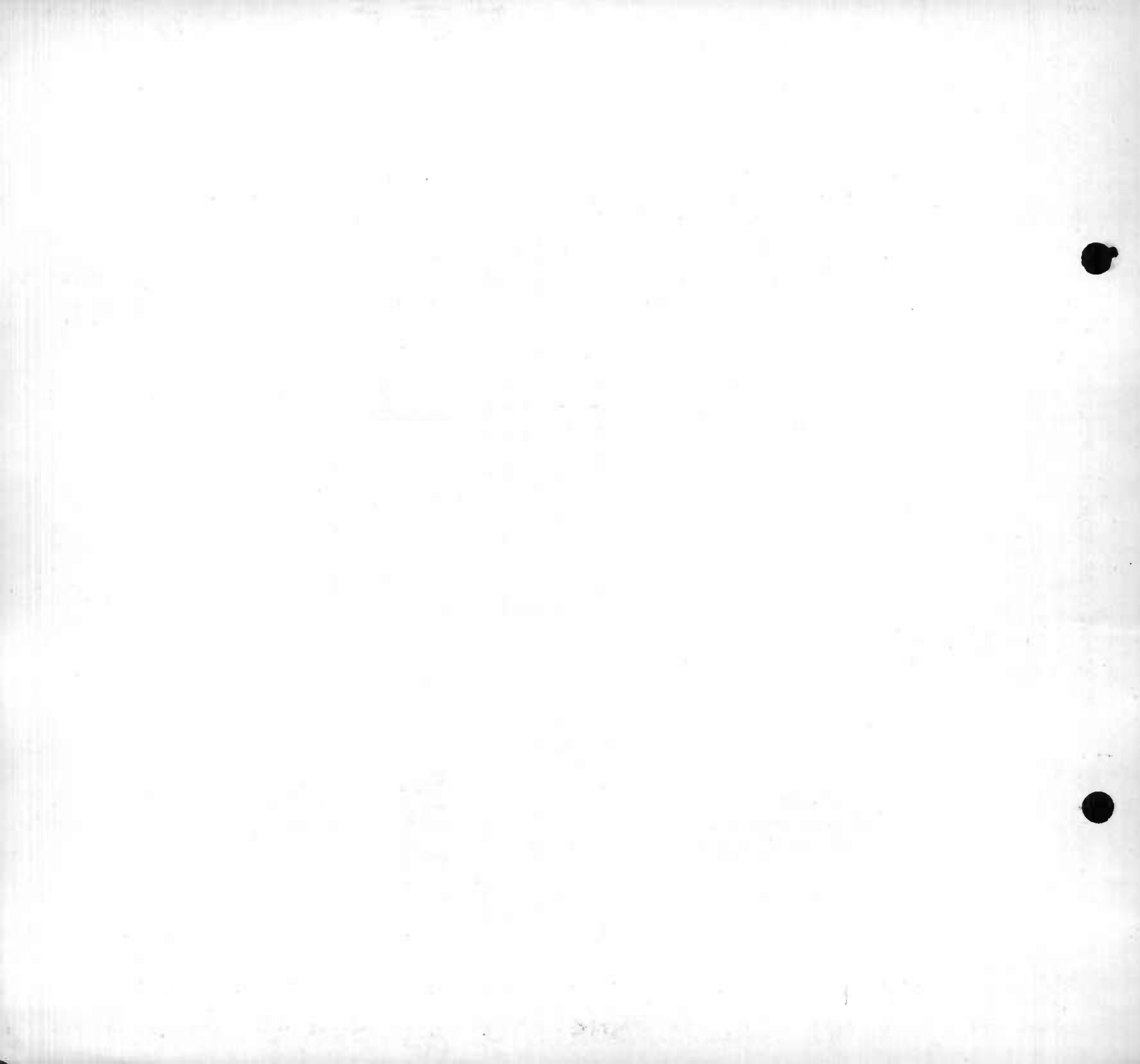
3035 W. North Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
p-456 70 3740		70 3740		70 3740	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) PALMER ROBERT		2. DATE AND HOUR OF DEATH 4. 6. 70 11. 40 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. 8. COUNTY 1511			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital 4730 Ashburton St. Baltimore, MD. 21216.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3520 HILTON RD.			
5. SEX M.	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5. 26. 93	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bethlehem Steel Co.		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Mary ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 213-07-1992A		17. INFORMANT Miss Elizabeth Palmer 2746 Riggs Avenue	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular accident (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4. 3. 70 4. 6. 70	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). urinary tract infection					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 4. 3. 1970 to 4. 6. 1970, that (I) (we) last saw the deceased alive on 4. 6. 1970 and that in (my) (of) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P. G. Names M.D.		23B. DATE SIGNED 4. 6. 70			
23C. PHYSICIAN'S NAME (Type) P. G. NAMES MD		23D. ADDRESS Lutheran Hosp 730 Ashburton St - Balto.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/70		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD.		25C. FUNERAL DIRECTOR Nutter Funeral Home 3035 W. North Ave.	



W-200 70

3741

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3741

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frederick Wise		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 4 70 7:25 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 504 W. Lafayette Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 4 70 7:25 a.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1402		6. SEX male 7. RACE colored 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 2/6/1900		10. AGE (In years last birthday) 70 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oban Wise		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian	
15. MOTHER'S MAIDEN NAME Agnes Queen		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 215-07-3267		18. INFORMANT ADDRESS Mr. Ollie Wise 2015 Madison Avenue	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner <input type="checkbox"/> DATE SIGNED 4/4/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/8/70	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Nutter Funeral Home		ADDRESS 3035 W. North Avenue	

ACCAIDILM YALDOL

ROBILLOTT

YALDOL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3742	
L-000 70 3742		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) JOHN LEE			2. DATE AND HOUR OF DEATH 4/6/70 4:55 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue BALTIMORE, MARYLAND 21224			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1537 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3336 Gwynns Fall Parkway 21216 007		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-23	9. AGE (In years last birthday) 47	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint Foreman
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paint Foreman		10B. KIND OF BUSINESS OR INDUSTRY U. S. Public Health		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME David Lee			14. MOTHER'S MAIDEN NAME Maude H. Hickman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII & Korean		16. SOCIAL SECURITY NO. 230-14-9943		17. INFORMANT BCH-Records 4940 Eastern Avenue Baltimore, Maryland 21224	
18. 431.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ANEMIA, RENAL FAILURE			CAUSE OF DEATH (A) IMMEDIATE CAUSE INTRACEREBRAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF: (B) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 1/2 HRS.		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RENAL FAILURE		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if) (this hospital) attended the deceased from 4/6/70 1970 to 4/6 1970 that (if) (we) last saw the deceased alive on 4/6 1970 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Dennis W. Bleakley MD DEGREE				23B. DATE SIGNED 4/6/70	
23C. PHYSICIAN'S NAME (Type) Dennis W. Bleakley MD. DEGREE		23D. ADDRESS BCH- 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/70		24C. NAME OF CEMETERY OR CREMATORY Baltimore, National Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Nutter Funeral Home 3035 W. North Avenue	

Called B G H
Operation for renal failure

Referred 1/27/76 CT

FUNERAL DIRECTOR: IMPORTANT

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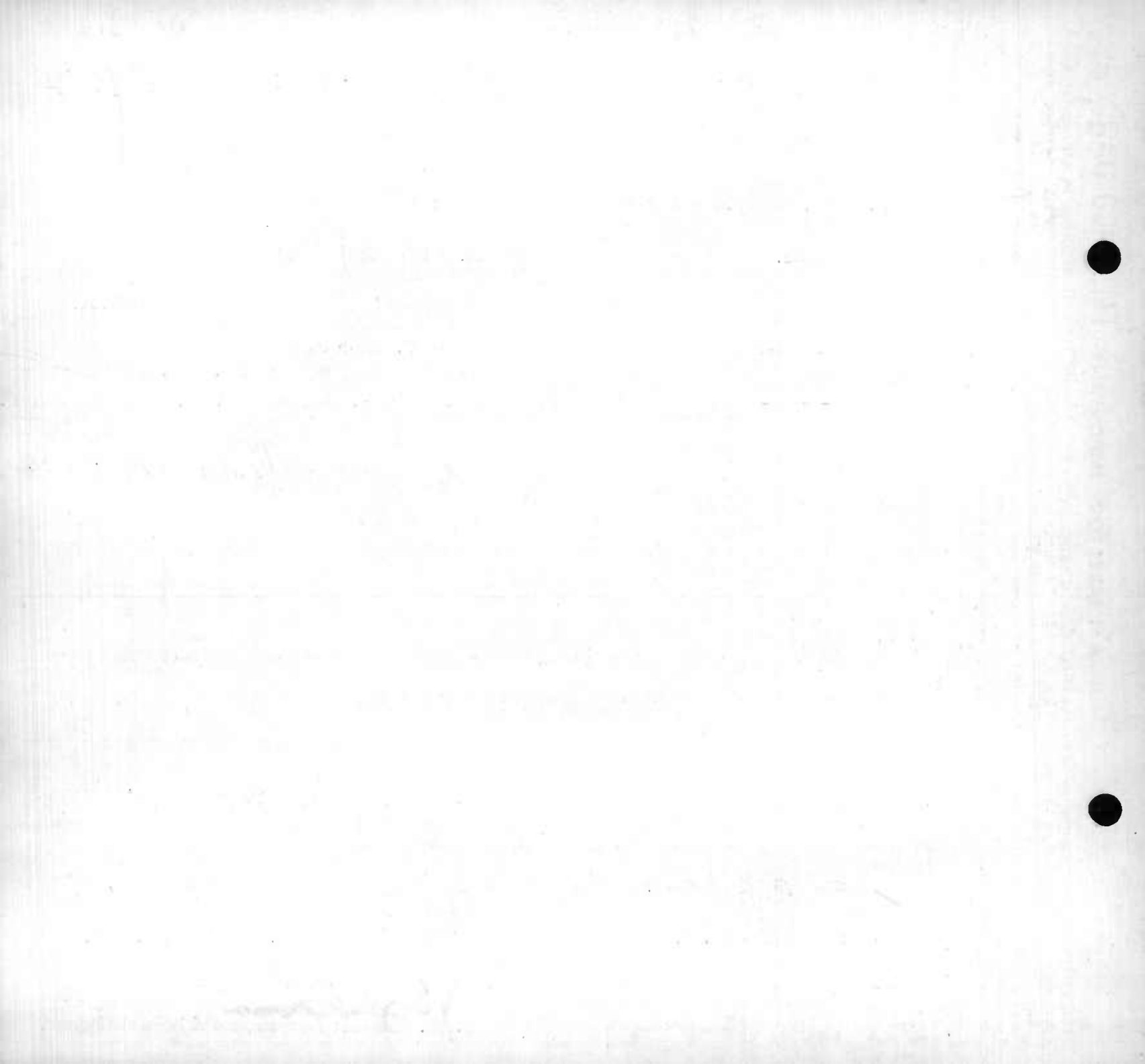
BALTIMORE CITY HEALTH DEPARTMENT									
S-524 70 3743					REG. NO. 70 3743				
BIRTH NO.					DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>PATRICK SINGLETON</u>					4/4/70 10 ⁰⁰ P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 HARBOR VIEW NURSING + CONVA. HOME</u> <u>1213 LIGHT ST</u>					A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>				
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION					C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
5. SEX <u>M</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>2/1/22</u> 9. AGE (in years last birthday) <u>48</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>					11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>				
10B. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Tom C. Singleton</u>					14. MOTHER'S MAIDEN NAME <u>Margie Murphy</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>132-22-5857</u>				
17. INFORMANT <u>My Ethel Murphy</u>					ADDRESS <u>500 E. 26TH ST</u>				
18. <u>45.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES					DUE TO, OR AS A CONSEQUENCE OF:				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					DUE TO, OR AS A CONSEQUENCE OF:				
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) <u>No</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>11/20/69</u> 19 <u>70</u> to <u>4/6</u> 19 <u>70</u>					that (I) (we) last saw the deceased alive on <u>4/5</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Joseph S. Blum MD</u>					23B. DATE SIGNED <u>4/7/70</u>				
23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM MD</u>					23D. ADDRESS <u>1115 N. Calver St</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>4/7/70</u>				
24C. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>					24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1970</u>					25B. NAME OF REGISTRAR <u>Frank Della</u>				
25C. FUNERAL DIRECTOR <u>Frank Della</u>					ADDRESS <u>322 N. High</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3744	
BIRTH NO. 6-450		70 3744	
1. NAME OF DECEASED (Type or Print) John Edward Gallon		2. DATE AND HOUR OF DEATH April 4, 1970 ✓ 10³⁰ M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2831	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4112 Fords Lane Baltimore, Maryland 21215		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4111 Hayward Avenue	
5. SEX Male	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH May 18, 1928
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Warehouse	9. AGE (In years last birthday) 41
		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Louis C. Gallon		14. MOTHER'S MAIDEN NAME Ida F. Donovan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216 20 7796	
		17. INFORMANT Balto. Md. 21215 Mr. John P. Gallon 4007 W. Belvedere Ave.	
18. 3-71.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 1970 to April 4, 1970 , that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Cecil Rudner M.D.		23B. DATE SIGNED April 5, 1970	
23C. PHYSICIAN'S NAME (Type) Cecil Rudner M.D.		23D. ADDRESS 6821 Reisterstown Road Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 Apr 70	
24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Dorsey, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor M.D.	
25C. FUNERAL DIRECTOR J. E. Lowell Lemmon		ADDRESS 4611 Park Hgts.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3745 ✓	
B-400 70 3745				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARTIN A BOLL			2. DATE AND HOUR OF DEATH APRIL 7, 1970 1:40 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1902		
FULL NAME OF HOSPITAL OR INSTITUTION UNIV. OF MD. HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M 6. RACE W			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-8-69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			10B. KIND OF BUSINESS OR INDUSTRY None		9. AGE (In years last birthday) 3 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) MD.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME HARRY S. BOLL			14. MOTHER'S MAIDEN NAME BARBARA KNIGHT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO. ---		17. INFORMANT Mr. Harry Boll
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 746.21			CAUSE OF DEATH CARDIORESPIRATORY ARREST		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CYANOTIC CONG. HEART DIS.		
			(B) EASD, VSD, PS & DOUBLE OUTFLOW DUE TO, OR AS A CONSEQUENCE OF:		
			(C) FROM ANTERIOR VENTRICLE		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4/6/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CATH. FOR DIAGNOSIS		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-1 19 70 to 4-7 19 70 that (I) (we) last saw the deceased alive on 4-7 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Felix L Kaufman M.D.				23B. DATE SIGNED 4-7-70	
23C. PHYSICIAN'S NAME (Type) FELIX L. KAUFMAN M.D.				23D. ADDRESS UNIV. HOSP. BALTO. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/9/70		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION Baltimore		24E. LOCATION (City, town, or county) (State) MD.		25A. DATE REC'D BY HEALTH DEPT. APR 9 1970	
25B. NAME OF REGISTRAR John J. Conway		25C. FUNERAL DIRECTOR John J. Conway & Son Inc.		25D. ADDRESS 9811 Phillips Rd. Balt. 364-25	

THE BODY OF MARY LAMAR HAS BEEN RELEASED AS NON MED BY DR FISHER OF
THE MEDICAL EXAMINER'S OFFICE
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 3746	
L-560 70 3746		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mary Lamar</u>		2. DATE AND HOUR OF DEATH <u>10:30 AM 4/6/70</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> <u>5300</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>		C. CITY OR TOWN <u>BALTIMORE ESSEX</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <u>318 OBERLE AVE</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-07-13</u>	9. AGE (In years lost birthday) <u>56</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>LOUIS SACHLOTTO</u>		14. MOTHER'S MAIDEN NAME <u>P</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK.</u>		16. SOCIAL SECURITY NO. <u>216-07-4737</u>		17. INFORMANT <u>RICHARD LAMAR</u> ADDRESS <u>ABOVE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>398X 4-15-70</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrest</u>		<u>1 hr</u>	
(B) <u>Rheumatic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) <u>Possible Colonic Ca ?</u>		<u>> 10 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 6 1970</u> to <u>April 6 1970</u> , that (I) (we) last saw the deceased alive on <u>April 6 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jeffrey D. Neill MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/6/70</u>	
23C. PHYSICIAN'S NAME (Typed) <u>Jeffrey D. Neill MD</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL OR CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/9/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>oak lawn</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1970</u>		25B. NAME OF REGISTRAR <u>John A. Fisher</u>		25C. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u> ADDRESS <u>300 MA...</u>	

Cardinalis ...
Rhinoceros ...
Purple ...

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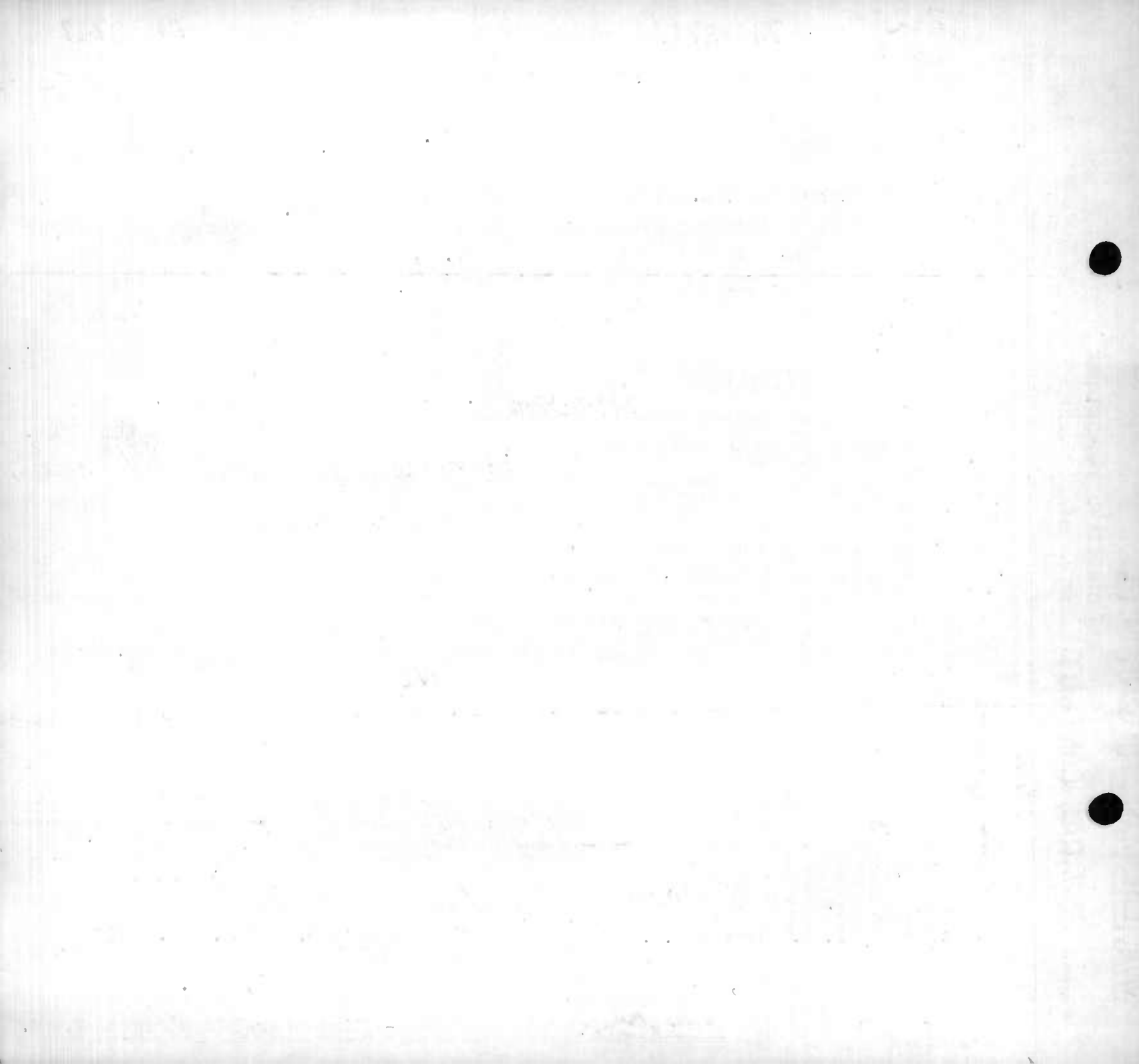
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

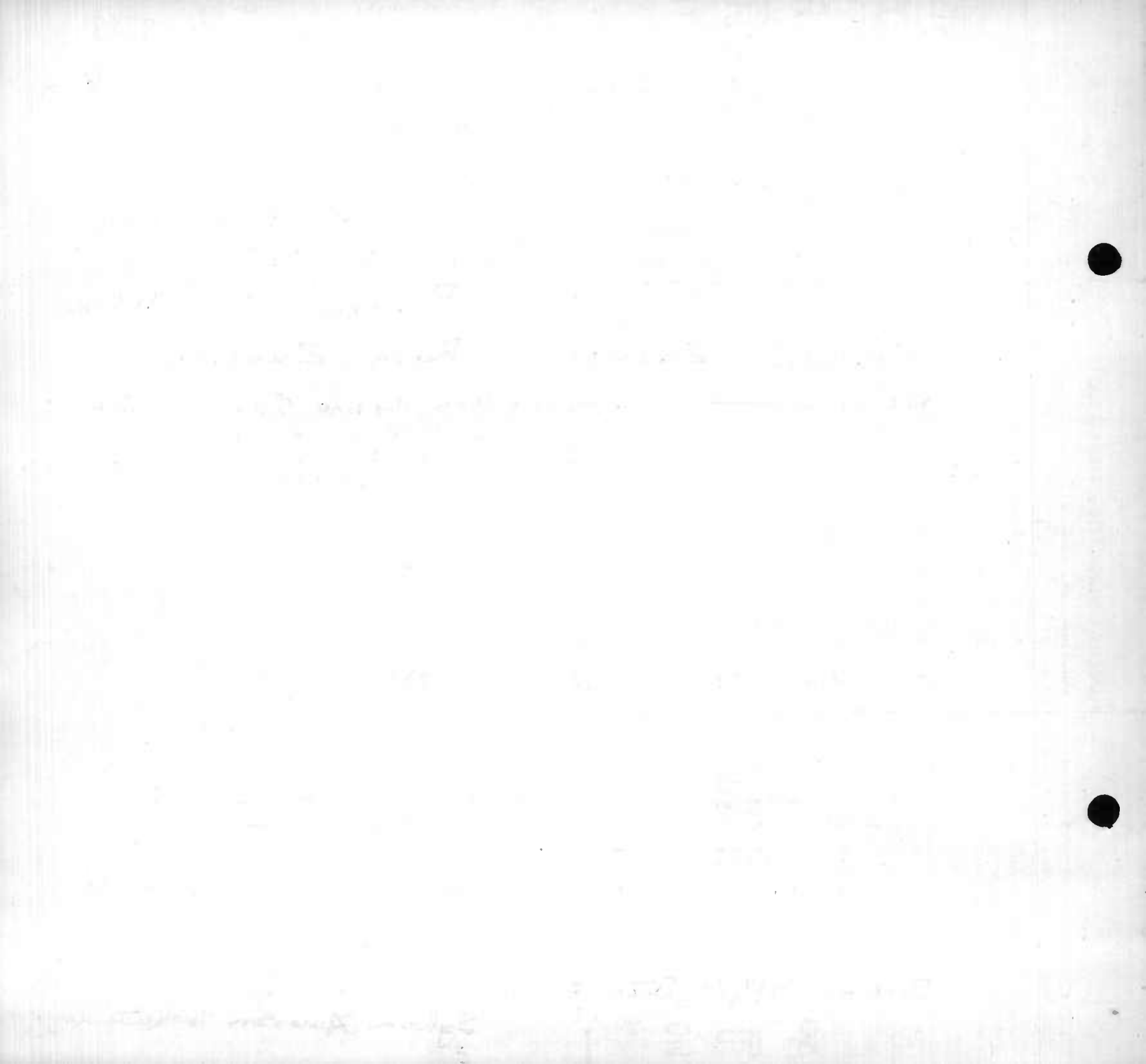
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 70 3747	
235 IRTH NO.		70 3747					
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) Theodore Zachidny				2. DATE AND HOUR OF DEATH 4/5/70 1 335P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospt.		(If not in hospital or institution, give street address or location)		A. STATE Md.		B. COUNTY 2643	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3748 Bonview Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH Nov. 25, 1887	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-8996		17. INFORMANT ADDRESS Mr. Zeny Zachidny Hapstead, Md. (Son)			
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Advanced Arteriosclerotic Cardiovascular Disease (B) Uremia (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/23 1968 to 4/5 1970 , that (I) (we) last saw the deceased alive on 4/4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE L. B. Stevens				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/7/70	
23C. PHYSICIAN'S NAME (Type) L. B. Stevens, M.D.				23D. ADDRESS 3400 Erdman Ave., Balto., Md. 21213			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 8, 1970		24C. NAME of CEMETERY or CREMATORY Immanuel Cemetery		24D. LOCATION (City, town, or county) (State) Manchester, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Tipton, M.D.		25C. FUNERAL DIRECTOR ADDRESS Tipton - Eline Funeral Home Hampstead, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

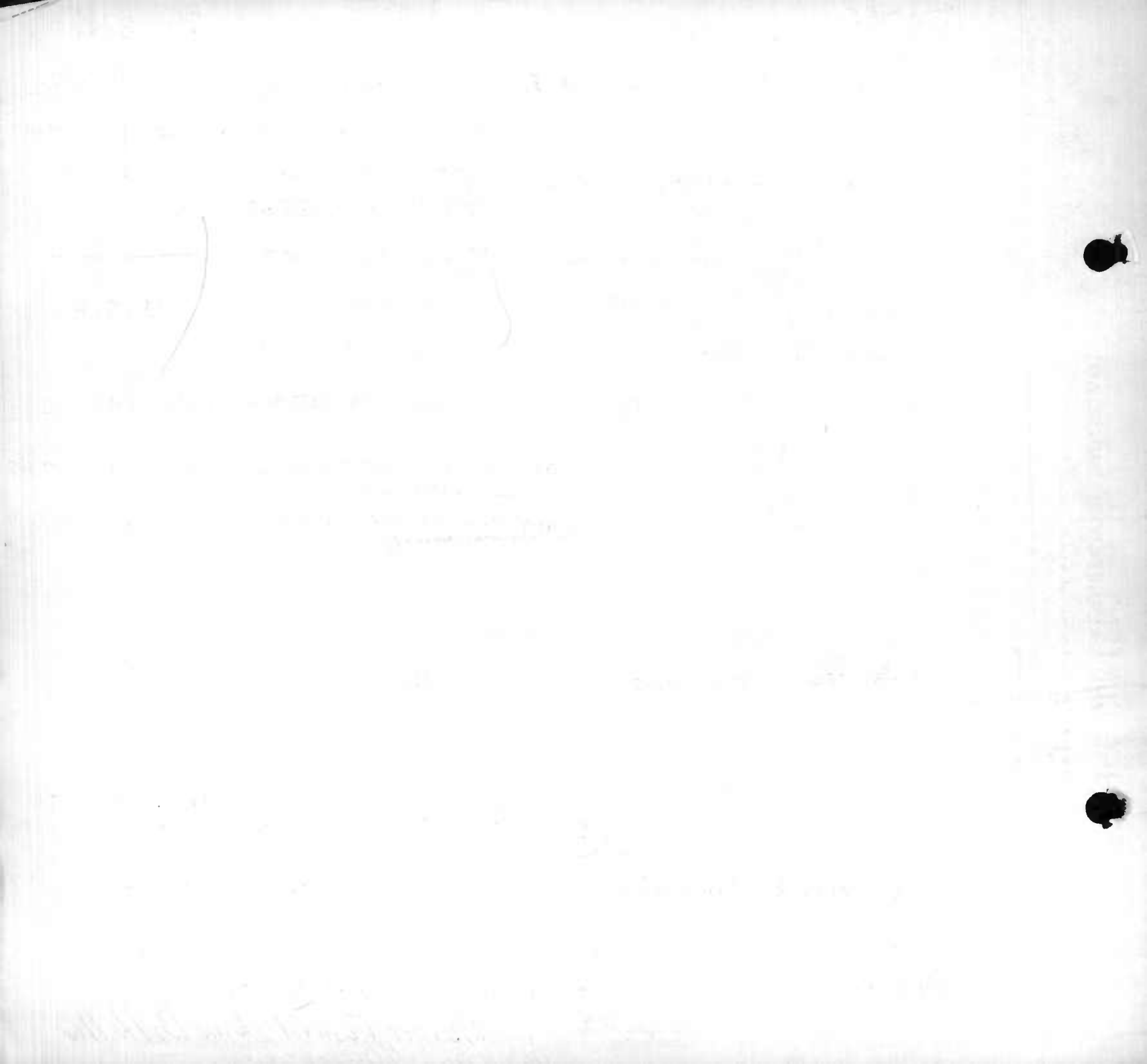
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3748	
Z-255 70 3748		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LILLIAN ZUSMAN		2. DATE AND HOUR OF DEATH APRIL 8, 1970 6 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5503 NARCISSUS AVE 00		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2719			
		C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5503 NARCISSUS AVE			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 17, 1914	9. AGE (In years last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME FRANK ZUSMAN		14. MOTHER'S MAIDEN NAME ROSA ZUSMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 491676-0098		17. INFORMANT MRS HANNA STREET	
				ADDRESS SAME	
18. 183.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH CANCER OF OVARY C METASTASIS TO ABDOMEN + (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: LUNG (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). NONE					
19A. DATE OF OPERATION JULY 1969		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF OVARY		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-30 19 70 to 4-8 19 70 , that (I) (we) last saw the deceased alive on 3-30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Leon Cushman M.D.		23B. DATE SIGNED 4-8-70		23C. PHYSICIAN'S NAME (Type) Leon Cushman	
		23D. ADDRESS BALTO		23E. FUNERAL DIRECTOR Sylvia L. Son	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/9/70		24C. NAME OF CEMETERY or CREMATORY Beth Shalom	
24D. LOCATION (City, town, or county) BALTO		24E. LOCATION (City, town, or county) MD		24F. LOCATION (City, town, or county) MD	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Vandyke		25C. FUNERAL DIRECTOR Sylvia L. Son	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. S-560		70 3749		70 3749	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) MISS MAUDE SKINNER			2. DATE AND HOUR OF DEATH APRIL 5, 1970 9:20 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL			A. STATE MD. B. COUNTY BALTIMORE (WESLEY HOME)		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21209		
			D. STREET ADDRESS (If rural, give location) 2211 W. ROGERS AVE 2755		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED	8. DATE OF BIRTH 9-20-82	9. AGE (In years last birthday) 87	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN SKINNER			14. MOTHER'S MAIDEN NAME LUCY DISNEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-30-9671	17. INFORMANT ADDRESS PATIENT & WESLEY HOME (ABOVE)		
18. 200.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) METASTATIC RETICULUM CELL LYMPHOMA DUE TO (B) MALIGNANT LEFT PLEURAL EFFUSION DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH MONTHS WEEKS					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 3-31-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DIAGNOSIS		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>March 20, 1970</u> to <u>April 5, 1970</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>April 5, 1970</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE Charles S. Harrison M.D.				23B. DATE SIGNED 4-5-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-7-70		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cem	
24D. LOCATION (City, town, or county) (State) B2/Ho Md					
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Burgee Funeral Home	
25D. ADDRESS B2/Ho Md					



FUNERAL DIRECTOR: IMPORTANT

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R-563 70-04670 3750		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3750	
1. NAME OF DECEASED (Type or Print) RICHARD REINHARD				2. DATE AND HOUR OF DEATH 4-7-70 2:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4703 ALDGATE GREEN			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1970	9. AGE (in years last birthday) 28	10. Under 1 Yr. Months 27	11. Under 24 Hrs. Days 27	12. Under 24 Hrs. Hours 27
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME RICHARD REINHARD			14. MOTHER'S MAIDEN NAME NANCY SMITH				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Richard Reinhard - 4703 Algate Green ADDRESS			
18. 757.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia, bil. DUE TO, OR AS A CONSEQUENCE OF: (B) Rubenskin - Taylor syndrome w/ other DUE TO, OR AS A CONSEQUENCE OF: (C) Longitudinal anomalies APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from March 9 19 70 to April 7 19 70 that the (we) last saw the deceased alive on April 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rodolfo R. Velasco M.D.				23B. DATE SIGNED 4-7-70		23C. PHYSICIAN'S NAME (Type) Rodolfo R. Velasco M.D.	
23D. ADDRESS Sinai Hospital				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-8-70		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR John E. [unclear]		25C. FUNERAL DIRECTOR John E. [unclear] ADDRESS John E. [unclear]			

4302 ABATE DRIVE

March 1, 1970

MARYLAND

NANCY

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Princeton, NJ

See notes

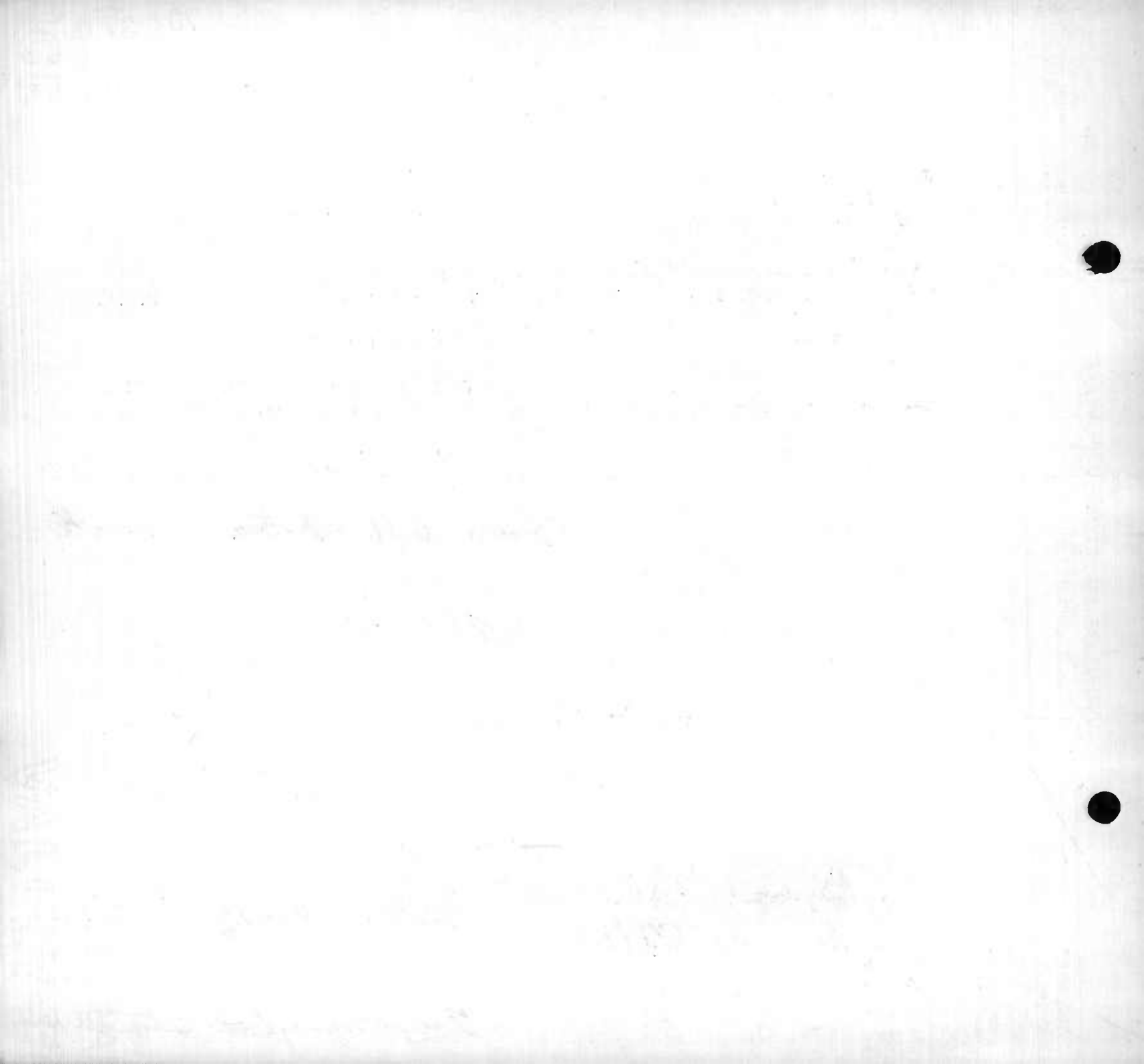
Princeton, NJ

Princeton, NJ

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> M-610 70 3751 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> BIRTH NO. REG. NO. 70 3751 </div>			
1. NAME OF DECEASED (Type or Print) Louis Michael Murphy		2. DATE AND HOUR OF DEATH April 6, 1970 3:48 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2008	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Jenkins Memorial Hospital 1000 Caton Ave. Baltimore, Maryland 21229		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 208 S. Loudon Ave.			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/81
		9. AGE (In years last birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman N.Y. Dept. City of Baltimore,		10B. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mose Murphy		14. MOTHER'S MAIDEN NAME Bridget O'Reilly	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes NO Unknown		16. SOCIAL SECURITY NO. 217-20-9149	
17. INFORMANT Jenkins Memorial Hospital 1000 Caton Ave. Baltimore, Md. 21229		ADDRESS	
18. 599.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bacteremia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic A.U. infection (B) DUE TO, OR AS A CONSEQUENCE OF: mouth (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ASCVD			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/16 19 66 to 4/6 19 70 , that (I) (we) last saw the deceased alive on 4/6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. Raymond Gladue		23B. DATE SIGNED 4/6/70	
23C. PHYSICIAN'S NAME (Type) J. Raymond Gladue		23D. ADDRESS Jenkins Memorial Hospital 1000 Caton Ave.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 4-10-70	
24C. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR John C. ...	
25C. FUNERAL DIRECTOR John C. ...		ADDRESS John C. ...	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3752	
BIRTH NO. H-453 70 3752		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Dorothy Holland		2. DATE AND HOUR OF DEATH April 3, 1970 2:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Harford C. CITY OR TOWN Havre de Grace D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 112 W. Washington Street 21078	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-7-27
9. AGE (In years last birthday) 43		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANT	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph ZUBER		14. MOTHER'S MAIDEN NAME Mary UNK.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. 483 186 664	
17. INFORMANT 4940 Eastern Avenue		18. ADDRESS BCH Records - Baltimore, Maryland 21224	
19. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 174 X I II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. radio resp arrest metastatic breast		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-18-69 19 69 to 4-3 19 70 , that (I) (we) last saw the deceased alive on 4-3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R. G. Haller M.D.		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) R. G. Haller, M.D.		23D. ADDRESS 4940 Eastern Avenue BCH Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/8/1970	
24C. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery		24D. LOCATION (City, town, or county) Havre de Grace, Harford Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR Remington, Jr., Havre de Grace, Md.		25D. ADDRESS Havre de Grace, Md.	

22X

FUNERAL DIRECTOR: IMPORTANT

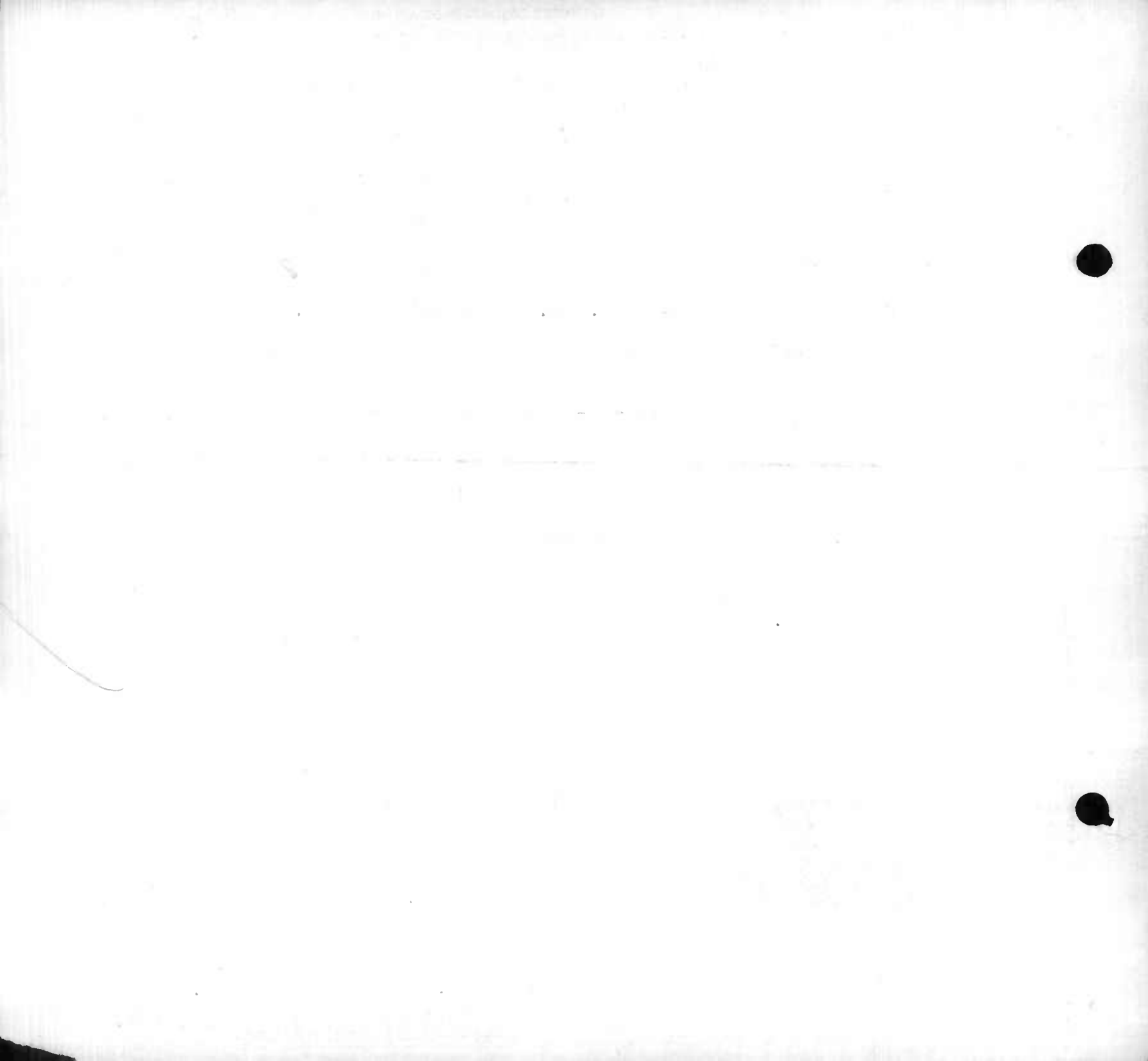
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3753	
<div style="font-size: 2em; font-weight: bold;">R-220</div> <div style="font-size: 2em; font-weight: bold;">70 3753</div>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
LOUIS RUZICKA		April 3, 1970 5 p. M.		00 2922 E. Madison Street	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		5. SEX		6. RACE	
Md., 21205		male		white	
C. CITY OR TOWN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Baltimore		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2/14/1900	
E. STREET AND NUMBER		9. AGE (In years lost birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
2922 E. Madison Street		70		Butcher	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Czechoslovakia		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
Joseph Ruzicka		unknown		216-01-6371	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
216-01-6371		Wilma Rys Ruzicka, wife, above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.4 I		Atherosclerotic C. V. Disease		5 yrs.	
ANTECEDENT CAUSES		DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		Generalized Atherosclerosis		Unknown	
II		DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Gastric Ulcer		2 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/7 1965 to 4/3 1970, that (I) last saw the deceased alive on 3/18 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. Henry Houska				4/6/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Henry Houska				333 S. East Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4/7/70		Bohemian National Cem.	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 9 1970		Schimunek Funeral Home, Inc.		3331 Brehms Lane	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3754	
C-414 70 3754 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) John ALBERT J. CLAYPOOLE		2. DATE AND HOUR OF DEATH 4.4.70 12³⁵ PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md 21213			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL / BALTO		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 3312 Dudley AVE.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/5/01	9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME William Claypoole		14. MOTHER'S MAIDEN NAME Eva Gumpman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-05-2835		17. INFORMANT Mamie Donnelly Claypoole, wife, above	
18. 436.991 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CEREBROVASCULAR ACCIDENT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DIABETES MELLITUS					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4.3.70 19 to 4.4.70 19 that (I) (we) last saw the deceased alive on _____ 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Bodenheimer MD				23B. DATE SIGNED 4.4.70	
23C. PHYSICIAN'S NAME (Type) M. Bodenheimer, M.D.		23D. ADDRESS Sinai			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/8/70		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem.	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 9 1970			
25B. NAME OF REGISTRAR John E. [unclear]		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.			
25D. ADDRESS 3331 Brehms Lane					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-420 70 3755		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3755	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Theresa Catherine Nelles		2. DATE AND HOUR OF DEATH 4/13/70 706 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 48 Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. 21213 B. COUNTY 2633			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3202 Ramona Ave.			
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/87	9. AGE (in years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY Schludeberg Krudle		11. BIRTHPLACE (State or foreign country) Penna.	
13. FATHER'S NAME Patrick Lane		14. MOTHER'S MAIDEN NAME Margaret Brown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 21B-03-9321		17. INFORMANT Katherine Fischer, dght. above	
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary vascular accident (C) Hypertensive cardiovascular disease yrs.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days 1 w 4	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 3/28 1970 to 4/3 1970 that (I) (we) last saw the deceased alive on 4/3 1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Louis E. Drenyer M.D.		23B. DATE SIGNED 4/13/70		23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS		23E. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/7/70		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME of FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25C. ADDRESS 3331 Brehms Lane	



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BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3756

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
		V. (DePOITIERS) Elizabeth Deportiers		Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		Month Day Year Hour 4 3 70 11:05 a.m.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Hopkins Hospital		A. STATE Maryland	
6. SEX female		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		B. COUNTY 804	
9. DATE OF BIRTH 5/17/92		10. AGE (In years lost birthday) 77		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Nicholas Hartman		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Eva Christian		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 216-05-0418D		18. INFORMANT 21093 Martin Schaller, son, 2401 Chitwood		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: diabetes mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 4/12/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner		DATE SIGNED 4/4/70		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 4/7/70		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. J. J. J.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane	

W. D. GILBERT

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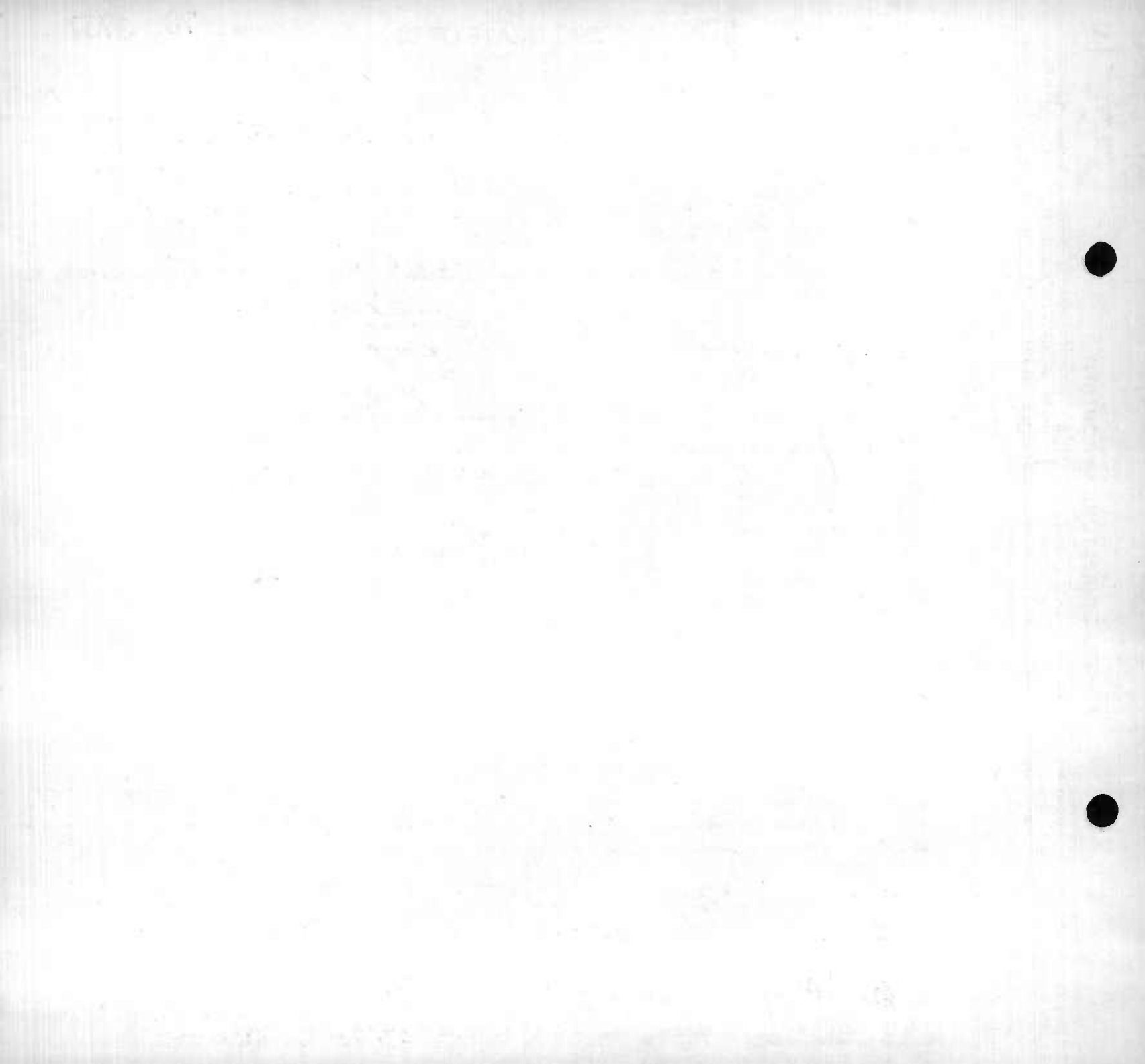
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-525 70 3757		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3757	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LOUISA JOHNSON		2. DATE AND HOUR OF DEATH 4/5/70 12:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ST. 1702			
FULL NAME OF HOSPITAL OR INSTITUTION KEY CIRCLE NURSING HOME 90 1214 EUTAW PLACE		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown 9. AGE (In years last birthday) 57		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) unknown 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Key Circle Nursing Home ADDRESS	
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GENERALIZED ARTERIOSCLEROSIS (B) SENILITY DUE TO, OR AS A CONSEQUENCE OF: (C) TERMINAL BRONCHOPNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/25 1963 to 4/5 1970 , that (I) (we) last saw the deceased alive on 4/5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gilbert L. Banfield MD		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/7/70	
23C. PHYSICIAN'S NAME (Type) GILBERT L. BANFIELD MD		23D. ADDRESS 722 N. Fulton Ave			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) Buried 4/9/70		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR Walter L. McCarroll ADDRESS 5312 North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3758	
T-416 70 3758		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Eltie Frances Tolbert		April 6 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
			A. STATE B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
House in the Pines - Belvedere			Bz H _o		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
90			E. STREET AND NUMBER		
			4115 Buena Vista Ave		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug 27 1884	85	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Seamstress		Textile Mill		Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Edward Cameron			Amanda Swartz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		213-01-6889		William Tolbert	
				ADDRESS	
				SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			1 yr.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Sept 19 69 to April 19 69, that (I) (we) last saw the deceased alive on April 6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Sheldon Goldgeier					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Sheldon Goldgeier				848 W 36th St	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-9-70		Good Shepherd Cem	
				Howard Co Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 9 1970		Robert E. Tolbert		Burgess Funeral Home	
				Bz H _o Md	

General Address

Multiple Payments

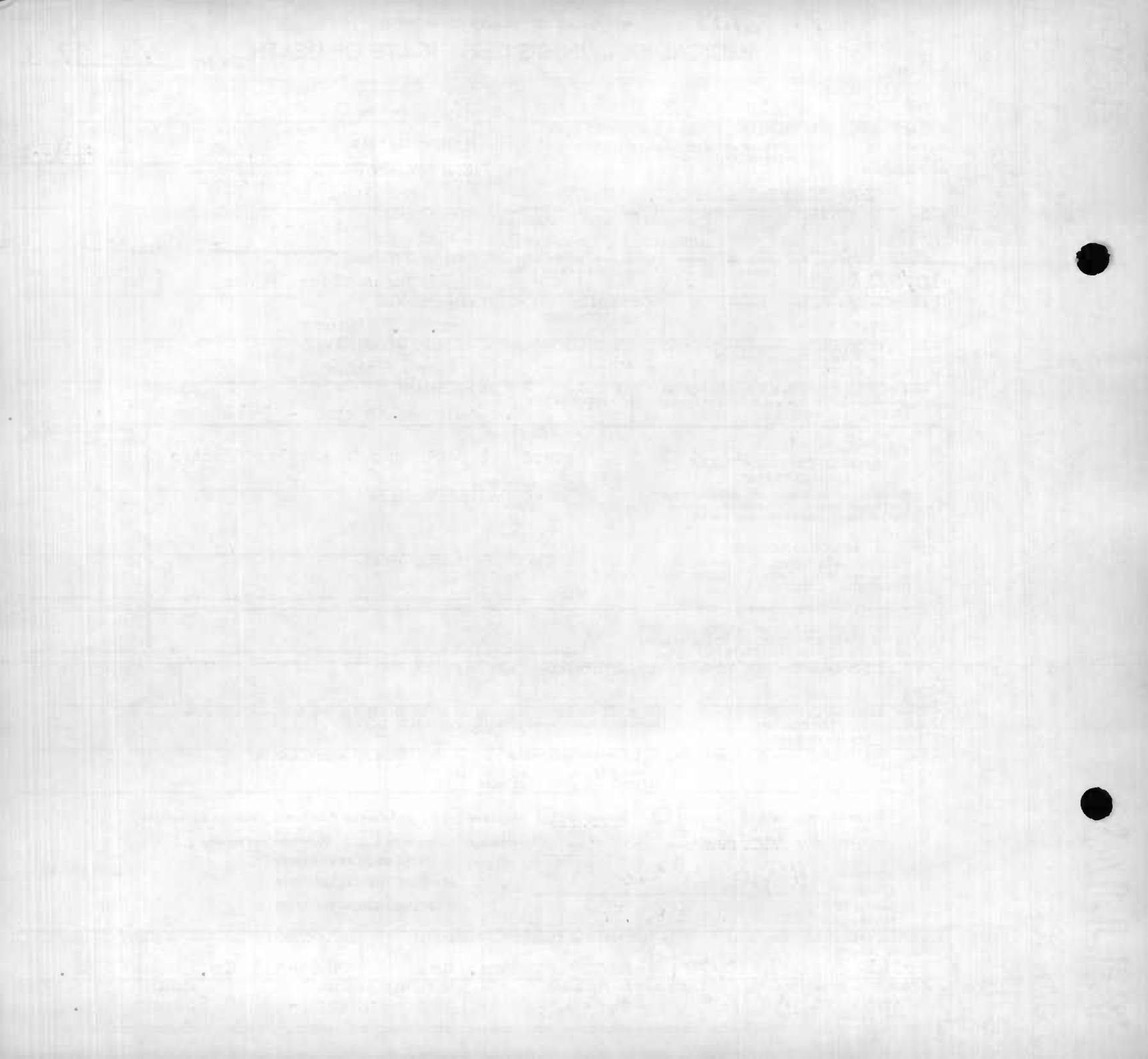
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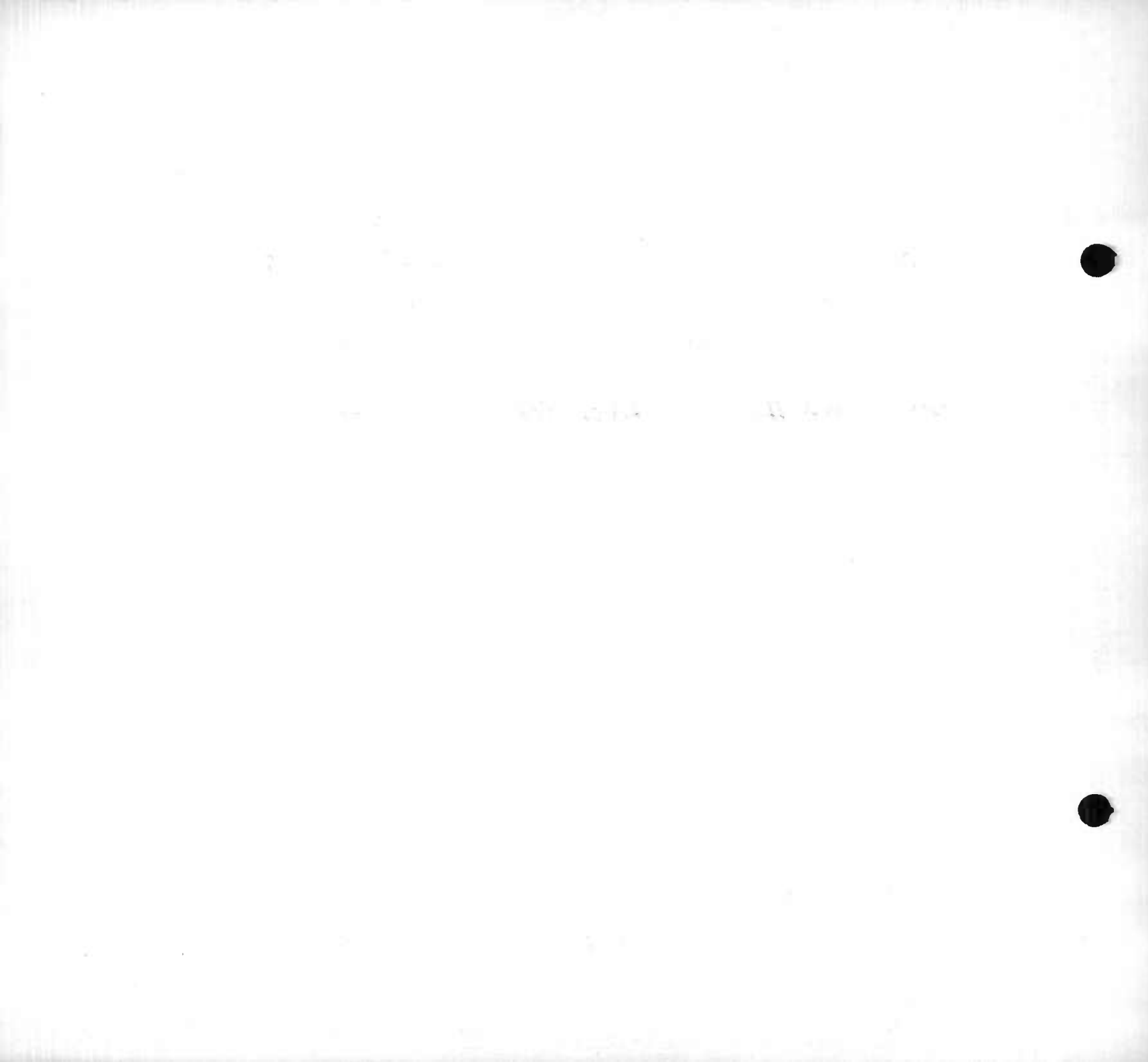
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HAROLD SHOUSE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 6, 1970 9:11 P. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1348	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10/9/15		10. AGE (In years lost birthday) 54 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 3511 Buena Vista Avenue	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		14B. KIND OF BUSINESS OR INDUSTRY Acme Markets		13. FATHER'S NAME Wm. S. Shouse	
15. MOTHER'S MAIDEN NAME Mary Hobbs		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes WWII		17. SOCIAL SECURITY NO. ?	
18. INFORMANT Edna M. Shouse		ADDRESS 3511 Buena Vista Ave.			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.4 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/7/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/70		24C. NAME of CEMETERY or CREMATORY Lake View Mem. Park	
24D. LOCATION (City, town, or county) (State) Carroll Co. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Ann Donovan		ADDRESS 3818 Roland Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3760</u>	
BIRTH NO. <u>K-425</u> <u>70 3760</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>William Klosinski</u>			2. DATE AND HOUR OF DEATH <u>4/7/70</u> <u>1:50 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>37</u> <u>Mercy Hospital, Inc.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2611</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37</u> <u>Mercy Hospital, Inc.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>11-15-15</u> 9. AGE (in years last birthday) <u>54</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Officer</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Klosinski</u>			14. MOTHER'S MAIDEN NAME <u>Mary Anne Winiecki</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u>			16. SOCIAL SECURITY NO. <u>218-01-9598</u>		17. INFORMANT <u>Hospital Records</u>
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute infectious MI complicated by shock and pulmonary edema</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>45</u> (this hospital) attended the deceased from <u>4-5-1970</u> to <u>4-7-1970</u> that <u>45</u> (we) last saw the deceased alive on <u>4-7-1970</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Bayani L. Manalo, M.D.</u> DEGREE				23B. DATE SIGNED <u>4-7-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>BAYANI L. MANALO, M.D.</u> DEGREE				23D. ADDRESS <u>Mercy Hospital 301 St. Paul Pl.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/11/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>ST. STANISLAUS</u>	
24D. LOCATION <u>DUNDALK</u>		24E. NAME OF REGISTRAR <u>John M. Weber & Sons</u>		24F. ADDRESS <u>401 S. CHESTER ST.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1970</u>		25B. NAME OF REGISTRAR <u>John M. Weber & Sons</u>		25C. FUNERAL DIRECTOR <u>John M. Weber & Sons</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 3761
C-420 70 3761		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <i>Cilyk, Fedora</i>		(FEDORA CILYK)		2. DATE AND HOUR OF DEATH <i>4-7-70 8:50 A.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>201</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Mt Sinai Hospital</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ADDRESS OR LOCATION <i>4613 Park Heights Ave.</i>			E. STREET AND NUMBER <i>2024 E. Lombard St.</i>		
5. SEX <i>7</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-09-98</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Charwomen</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Office Building</i>		11. BIRTHPLACE (State or foreign country) <i>Ukraine</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Ukraine</i>			13. FATHER'S NAME <i>George Suhaniak</i>		
14. MOTHER'S MAIDEN NAME <i>Yowdokha ?????</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No -</i>		
16. SOCIAL SECURITY NO. <i>215-30-0733</i>			17. INFORMANT ADDRESS <i>Mr. Daniel Cilyk, 2024 E. Lombard St.</i>		
18. <i>412.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Bacterial pneumonia</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>arteriosclerotic heart disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Thrombosis</i>		<i>1 year</i>	
(C) <i>none</i>				<i>4 weeks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 1</i> 19 <i>70</i> to <i>April 7</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>April 7</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Manuel Levin M.D.</i>				23B. DATE SIGNED <i>4/7/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN M.D.</i>				23D. ADDRESS <i>6161 Park Hgts Ave Bldg -15 Mt</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/11/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Andrew</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 9 1970 Robert E. Taylor M.D.</i>			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <i>M.F. SADOWSKI & SONS, 1808 EASTERN AVE.</i>			

MANUEL LEVIN NO 101 Park Ave New York City
APR 17

APR 17 1947

Mr
Mr

Carlson Thompson

Address: 101 Park Ave New York City

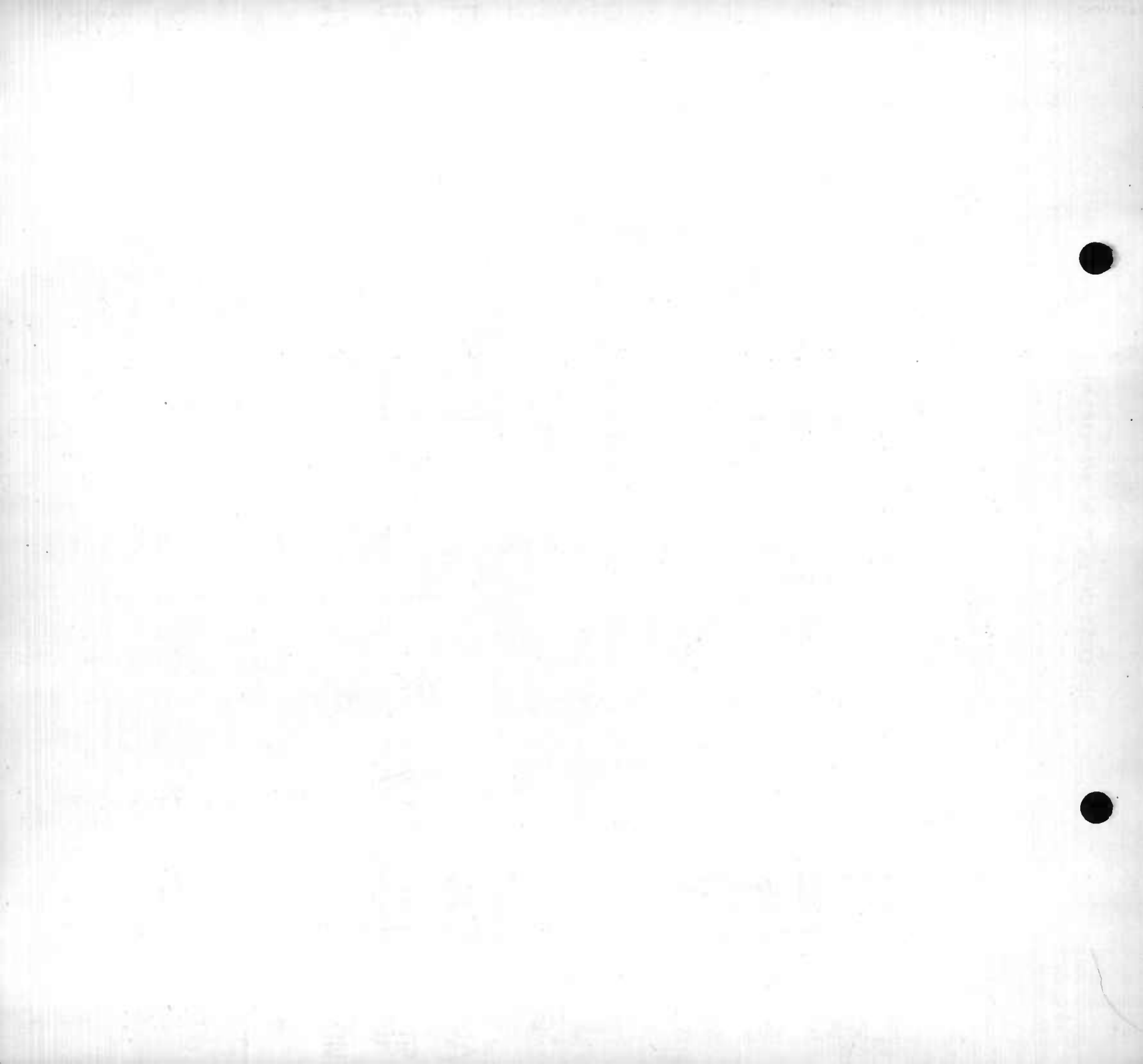
Black Mountain

1 copy
1 copy
1 copy

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3762	
R-534 70 3762		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Randolph, John J.</i>		2. DATE AND HOUR OF DEATH <i>4-7-70 3:25 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1601</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>46 Lutheran Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1228 Mosker Street</i>		5. SEX <i>Male</i> 6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>1-19-01</i>		9. AGE (In years lost birthday) <i>69</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>W. VA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>W. M. RANDOLPH</i>		14. MOTHER'S MAIDEN NAME <i>LULA MITCHEL</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Geo. Randolph 812 N. Strickon</i>	
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		A. IMMEDIATE CAUSE <i>Uraemia</i> DUE TO, OR AS A CONSEQUENCE OF: B. <i>Post. Op. TUR</i> DUE TO, OR AS A CONSEQUENCE OF: C.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>3:30</i> 19 <i>70</i> to <i>4:7</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>4-7</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <i>4-7-70</i>		23C. PHYSICIAN'S NAME (Type) <i>DR. Y. BARBARO</i>	
23D. ADDRESS <i>RD. LUTHERAN HOSPITAL, BALTO-16 MD</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/11/70</i>	
24C. NAME OF CEMETERY or CREMATORY <i>MT Aiden</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 9 1970</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR <i>James H. Hayes</i>		25D. ADDRESS <i>635 N. Graham</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

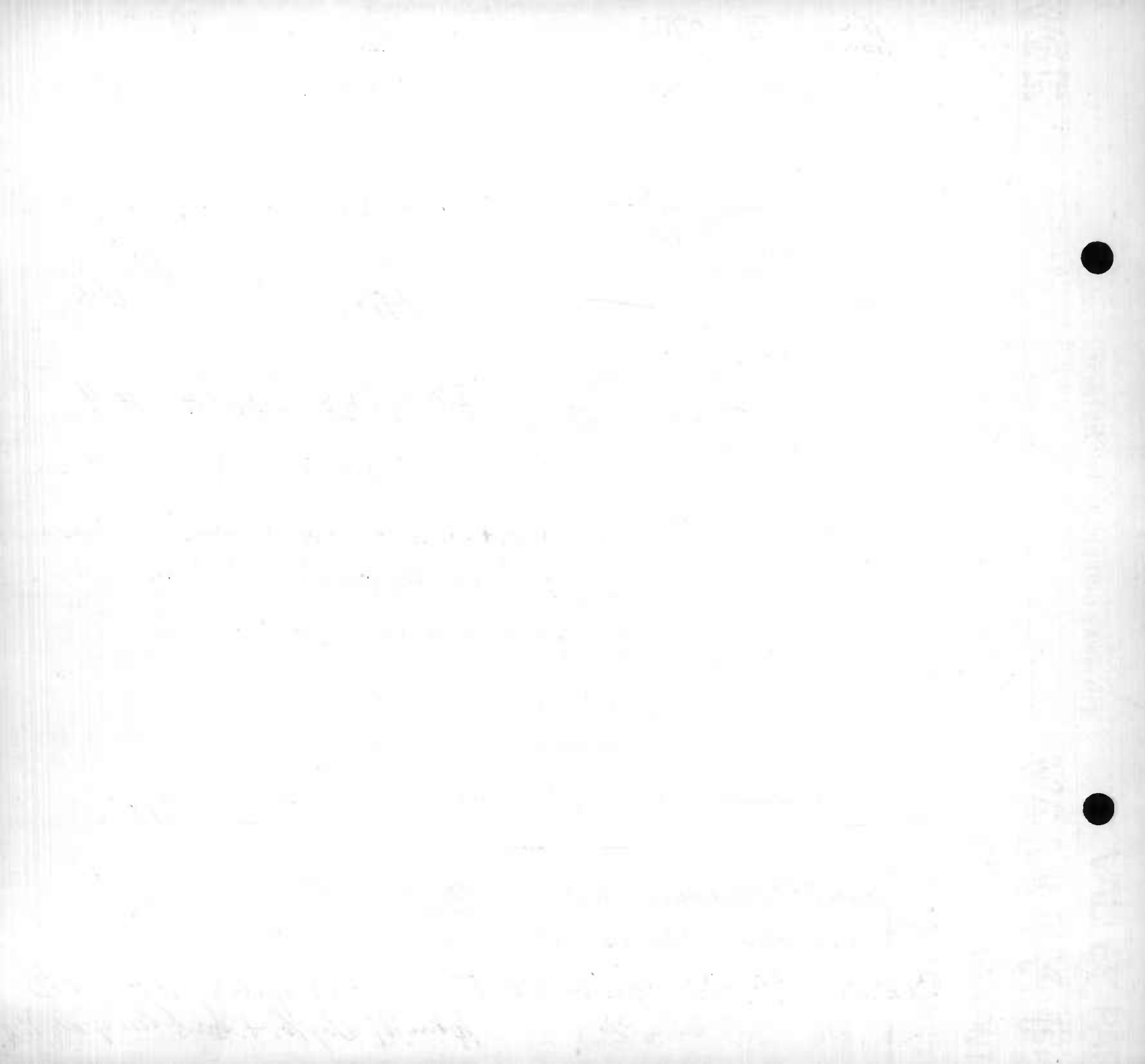
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. H-616		70 3763		70 3763	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) JAMES H. HARPER				April 6 - 1970 1:15 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
CERTIFICATE AMENDED FULL NAME OF DECEASED (If not in hospital or institution, give street address at location) 37 MERCY Hosp				A. STATE MD B. COUNTY 1205 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 415 E. FEDERAL ST	
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-14-1905	9. AGE (In years last birthday) 64	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10B. KIND OF BUSINESS OR INDUSTRY BALTO GAS & ELECTRIC		11. BIRTHPLACE (State or foreign country) North Carolina
13. FATHER'S NAME F. B. HARPER			14. MOTHER'S MAIDEN NAME LOUVENIA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 217-03-4062		17. INFORMANT Pauline Harper
18. 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH minutes
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/16 19 70 to 4/4 19 70 , that (I) (we) last saw the deceased alive on 4/4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James J. McPhillips				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) JAMES J. McPHILLIPS M.D.				23D. ADDRESS 2 E. Read St., Baltimore Md	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/13/70		24C. NAME of CEMETERY or CREMATORY ARBURUS MON PK	
24D. LOCATION ARBURUS - BALTIMORE 21227		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR RECEIVED	
24G. DATE REC'D BY HEALTH DEPT.		24H. NAME OF REGISTRAR RECEIVED		24I. FUNERAL DIRECTOR Marshall A. Wynn	
24J. ADDRESS 638 N. GILMAN ST					

1920 Federal Census for James H. Harper - age
14 - born in North Carolina to Eb & Luvenia
Harper and V.S. 153 4-20-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530 70 3764		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3764	
BIRTH NO. <i>Anne Arundel Co. Md.</i>				1. NAME OF DECEASED (Type or Print) <i>Smith, Baby Girl</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <i>4/5/70 6⁰⁵ P. M.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>The Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i>		C. CITY OR TOWN <i>Riva</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/4/70</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Douglas Smith</i>				14. MOTHER'S MAIDEN NAME <i>Deborah Warren</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Douglas Smith #4</i>		ADDRESS	
18. <i>7764 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>cardiac arrest</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>hypaline membrane disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>possible congenital heart disease</i> (C) <i>possible intracerebral hemorrhage</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4/5</i> 19 <i>70</i> to <i>4/5</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>4/5</i> 19 <i>70</i> and that in (my) (their) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.							
23A. SIGNATURE <i>James Wm. Hanson MD</i>				23B. DATE SIGNED <i>4/5/70</i>		Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>JAMES Wm. HANSON MD</i>				23D. ADDRESS <i>The Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-7-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Hillcrest</i>		24D. LOCATION (City, town, or county) (State) <i>Annapolis, A.A. MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 9 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>John M. Lytle & Sons Annapolis, Md.</i>		ADDRESS	



C-320

70 3765

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3765

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ERSKINE CADES

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SOUTH BALTO. GENERAL HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

March 17, 1970

10:22 AM

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2506

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Unknown

10. AGE (In years
lost birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3217 Fairfield

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

2-14-16-80

18. INFORMANT

Frank Gamber 1600 Cameron

ADDRESS

19.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A.

DATE OF OPERATION

20B.

CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/18/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/9/70

24C. NAME of CEMETERY or CREMATORY

mtanbur

24D. LOCATION (City, town, or county)

Baltimore, Md

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

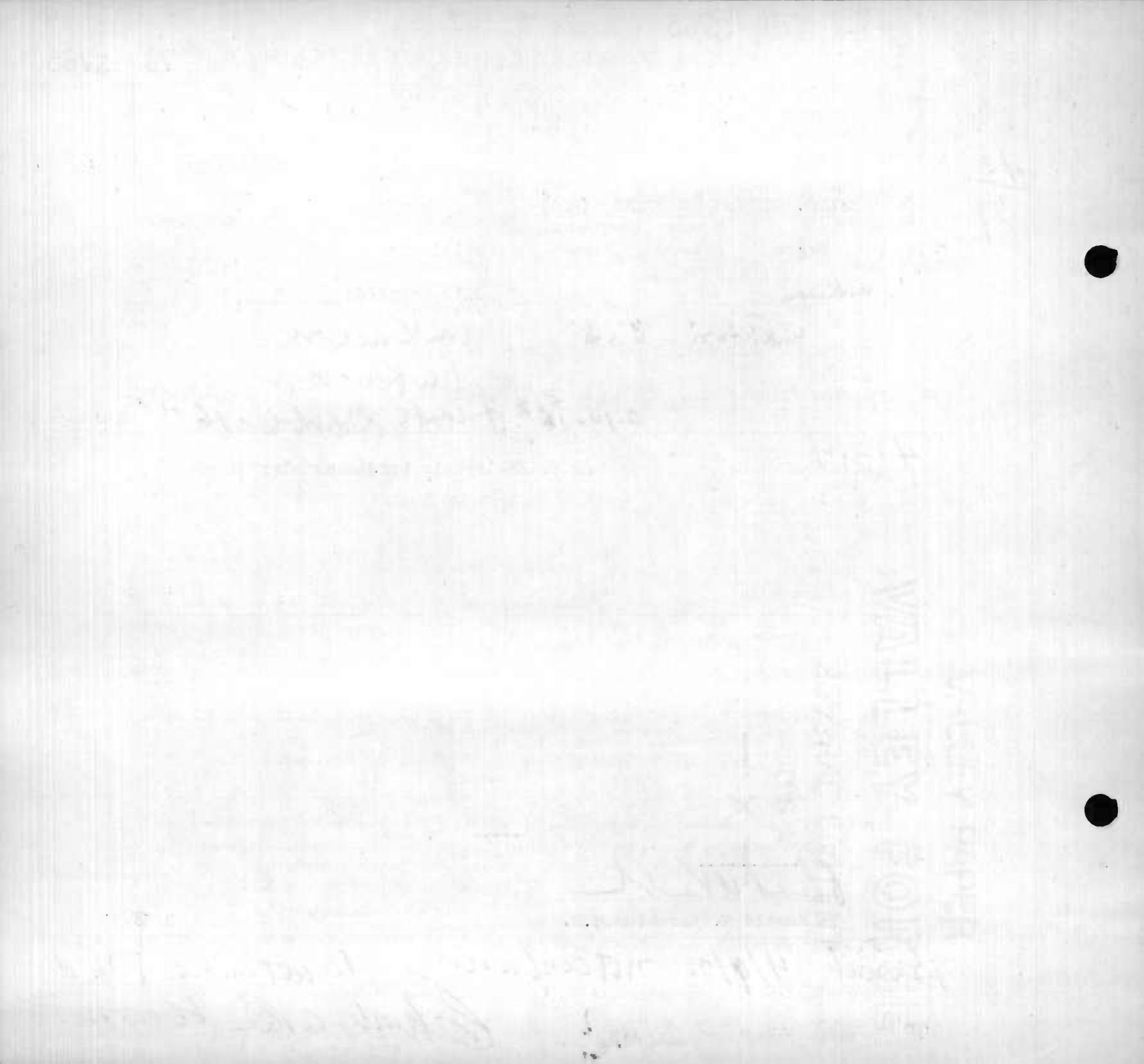
25C. FUNERAL DIRECTOR

ADDRESS

APR 9 1970

R. N. Kornblum, M.D.

Charles A. Rice 661 W. Bore



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3766	
E-420 70 3766				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>CLARA Ellis or CLARA McFADDEN</u>		2. DATE AND HOUR OF DEATH <u>4/8/70</u> 1 4²⁰ A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2101</u>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Univ. of Md. Hospital</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6/11/28</u>		9. AGE (In years lost birthday) <u>41</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>Ozella</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>UNKNOWN</u>	
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>UTI</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ureteral Herniation</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 DAYS</u>	
(B) <u>RIGHT CVA, old</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) <u>Hypothermia 2° exposure</u>		<u>UNKNOWN</u> <u>> 30 DAYS</u>	
19A. DATE OF OPERATION <u>3/13/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RIGHT CVA</u>		20A. AUTOPSY? (Yes or No) <u>NONE</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/9</u> 19 <u>70</u> to <u>4/8</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles L. Cromwell</u>				23B. DATE SIGNED <u>4/8/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles L. Cromwell</u>				23D. ADDRESS <u>661 W. BARRE ST</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/11/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>INT CALVERY</u>	
24D. LOCATION <u>BROOKLYN MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD.</u>	
25C. FUNERAL DIRECTOR <u>CHARLES A. RICE</u>		25D. ADDRESS <u>661 W. BARRE ST</u>		25E. DATE SIGNED <u>4/8/70</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
G-620 70 3767						70 3767	
1. NAME OF DECEASED (Type or Print) GRAVES, HATTIE L.				2. DATE AND HOUR OF DEATH 4-8-70 3:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MD		B. COUNTY BALTO.	
C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 446 CHALFONTE DR. 21228			
5. SEX FEMALE	6. RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/84	9. AGE (In years last birthday) 85	10. Under 1 Yr. Months Days 6 17	11. Under 24 Hrs. Hours Min. 17	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) GEORGIA	
13. FATHER'S NAME JACK ALLEN			14. MOTHER'S MAIDEN NAME MOLLY RUSSELL			12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT Dorothy Bratton-446 Chalfonte		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD & Failure.			IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe Secondary Anemia. Fracture of hip. Chronic Brain Syndrome.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3-3-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture Hip.		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 446 Chalfonte Ave 21228			
21D. TIME OF INJURY (APPROX.) 2-27-70		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell off chair onto Floor 2-27-70 to 4-8-70			
22. I certify that (I) (this hospital) attended the deceased from 4-8-70 to 4-8-70 and that (I) (we) last saw the deceased alive on 4-8-70 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE V. VARASOBIN, M.D.				23B. DATE SIGNED 4-8-70			
23C. PHYSICIAN'S NAME (Type) VARASOBIN, M.D.				23D. ADDRESS Bon Secours Hosp. Balto. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE		24C. NAME OF CEMETERY or CREMATORY College Park		24D. LOCATION (City, town, or county) (State) College Park, GA.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Wilgho-1630 Edmondson Ave		ADDRESS	

2000-01-01

2000-01-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3768	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Teresa Arnold		2. DATE AND HOUR OF DEATH 4/8/70 8:15 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Nursing Home 6116 Belair Road			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 1101 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 101 E. Mt. Royal Avenue		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/86	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John Sheridan		
14. MOTHER'S MAIDEN NAME Kathleen Hubbard			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 112-03-4349			17. INFORMANT 36 Murray Blvd Mrs. Robert B. Russell, Charleston, S. C.		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. </div> <div style="width: 45%;"> A) IMMEDIATE CAUSE Gastrointestinal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF: Etiology unknown. </div> <div style="width: 10%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several days </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fractured Lf Hip; ASCVD					
19A. DATE OF OPERATION 2/12/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture, L Hip		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) UNKNOWN.	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 2 9 1970		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Slipped and fell on icy street.	
22. I certify that (I) (this hospital) attended the deceased from 4/7/1970 and that in (my) (our) opinion death occurred on the date 4/8/1970 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Albert Bradley				23B. DATE SIGNED 4/8/70	
23C. PHYSICIAN'S NAME (Type) Dr. Albert Bradley				23D. ADDRESS 4900 Belair Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/70		24C. NAME OF CEMETERY or CREMATORY Arlington National Cemetery	
24D. LOCATION (City, town, or county) (State) Arlington, Va.		25A. DATE REC'D BY HEALTH DEPT. APR 9 1970			
25B. NAME OF REGISTRAR Robert E. Witzke				25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Avenue., 21228	

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ASTOR LENOX TILDEN FOUNDATION
155 E. 42ND ST. N.Y.C. 17

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3769</u>	
<div style="display: flex; justify-content: space-between;"> <u>S-163</u> <u>70</u> <u>3769</u> CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SHEPPARD, MARY</u>		2. DATE AND HOUR OF DEATH <u>4/8/70</u> <u>8:00 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2101</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MD Hosp.</u>		C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>820 Mangold Balto Md</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/26/1894</u>	9. AGE (In years last birthday) <u>75</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto Md - USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Adolph Slaughter</u>		14. MOTHER'S MAIDEN NAME <u>NORA FOSTER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. Margaret Burdette</u> ADDRESS <u>Patient: CHART 820 Mangold St.</u>	
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>None</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>ACUTE M.I.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASEVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>double mitels</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>NO</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>NO</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NO</u>		21E. INJURY OCCURRED White At Work <input type="checkbox"/> <u>M</u> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NO</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>3/26/70</u> 19 <u>70</u> to <u>4/8</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/7/70</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harold J. Kaplan M.D.</u>				23B. DATE SIGNED <u>4/8/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. HAROLD J. KAPLAN</u>				23D. ADDRESS <u>Un. of Md Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/11/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Witzke, 4101 Edmondson Ave., 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

70 3770

CERTIFICATE OF DEATH

70 3770

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

NORDEN, JOHANNA

2. DATE AND HOUR OF DEATH

4/6/70 11:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 SOUTH BALTIMORE GENERAL HOSP.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

E. STREET AND NUMBER

1459 ANDRE STREET

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

F

6. RACE

W

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

7-31-91

9. AGE (in years last birthday)

78

10. Under 1 Yr. 11. Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife Packer

10B. KIND OF BUSINESS OR INDUSTRY

Packing House

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CARL CHRISTIAN

14. MOTHER'S MAIDEN NAME

MARY LACER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

220-05-0441

17. INFORMANT

HOSPITAL RECORDS

ADDRESS

18.

410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

MYOCARDIAL INFARCTION

(B) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE

DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/6/70 to 4/6/70 that (I) (we) last saw the deceased alive on 4/6/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

MARIANO A. TOLENTINO

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4/6/70

23C. PHYSICIAN'S NAME (Type)

MARIANO A. TOLENTINO

23D. ADDRESS

SOUTH BALTIMORE GEN HOSP.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/9/70

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 9 1970

25B. NAME OF REGISTRAR

Robt E. Fahey, M.D.

25C. FUNERAL DIRECTOR

Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 3771	
BIRTH NO. 70 3771		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Virginia Hill		4-9-70		5:10 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39		A. STATE Maryland		B. COUNTY 1302	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-28-06		9. AGE (In years last birthday) 63		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John T. Floyd		14. MOTHER'S MAIDEN NAME Ella Bell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-60-5459		17. INFORMANT Mr. John Hill - Husband	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 431.0 I CAUSE OF DEATH CEREBRAL HEMORRHAGE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: (C) ESSENTIAL HYPERTENSION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/9/70		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/6 to April 9, 1970 that (I) (we) last saw the deceased alive on April 9, 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gilbert L. Banfield M.D.		23B. DATE SIGNED 4-9-70		23C. PHYSICIAN'S NAME (Type) Gilbert L. Banfield M.D.	
23D. ADDRESS 722 N. Fulton Ave		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-70	
24C. NAME of CEMETERY or CREMATORY Carver Men Park		24D. LOCATION Maiden Lane		24E. CITY, TOWN, or COUNTY (State) Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. APR 9 1970		25B. NAME of REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Joseph L. Rasmussen	
25D. ADDRESS 2222 N. North Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

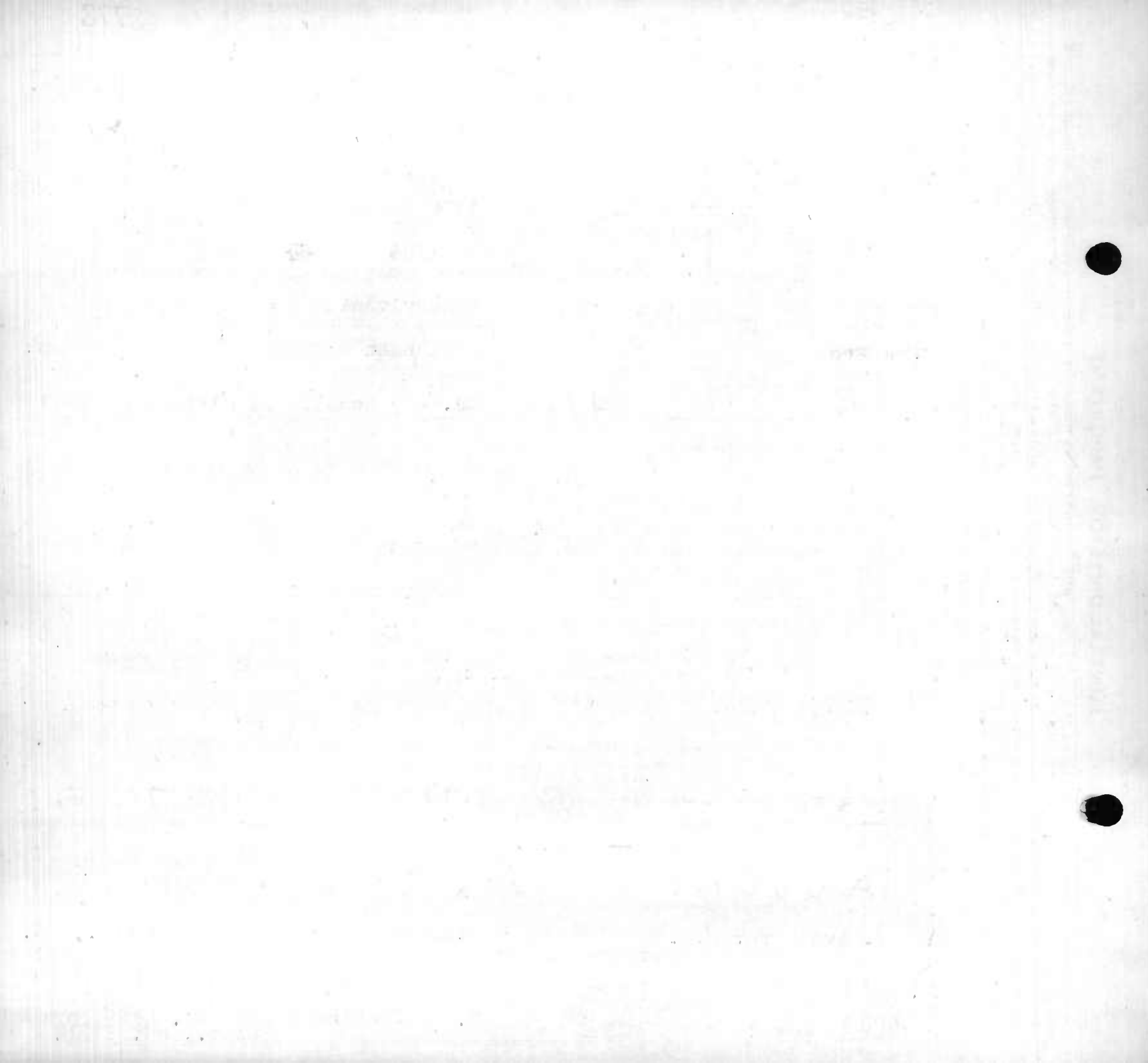
BALTIMORE CITY HEALTH DEPARTMENT				70 3772		REG. NO.	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Mary Ethel Walton		April 7, 1970	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
90 House In The Pines - Belvedere				Maryland		2759	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				4216 Kelway Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9-23-1878	91			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Instructor		Physiotherapy		North Carolina		U.S.A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George M. Walton				Mary Alice Worthen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		220-44-5726		Mr. Kenneth W. Blackeslee Same			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia Old age + no restraint. 1 day			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Sept 6 1968 to April 7 1970 that (I) (we) last saw the deceased alive on April 3 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. Lester N. Kolman				4/9/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Lester N. Kolman				Reisterstown Road Balto., Md. 6821			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-10-70		Woodlawn Cemetery		Woodlawn Balto., Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 9 1970		E. J. Taylor, M.D.		H. W. Jenkins & Sons Co.		4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

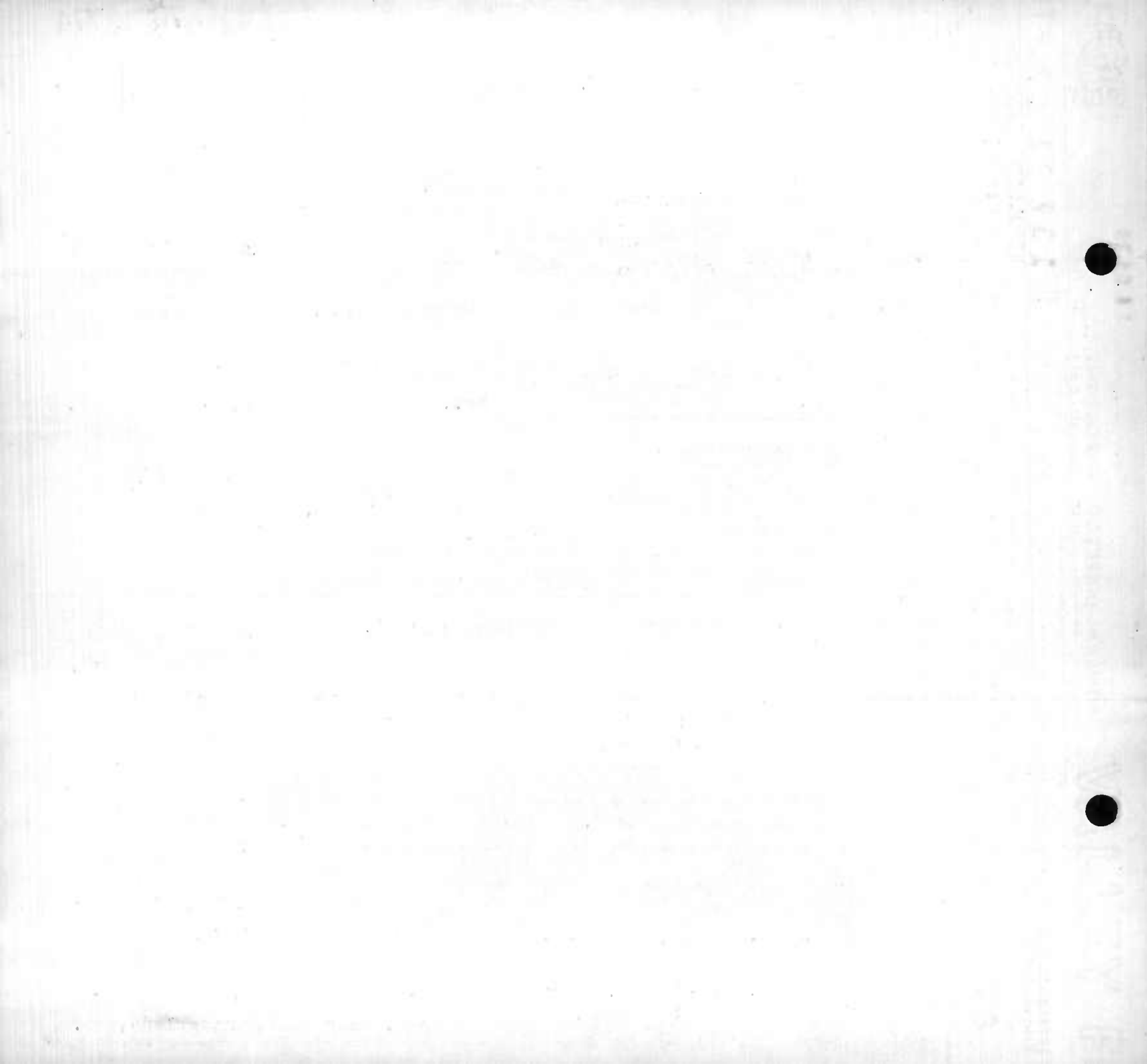
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3773	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Frances Mary Scholz		2. DATE AND HOUR OF DEATH 4/8/70 12:25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Cleveland, Ohio B. COUNTY Cleveland		
FULL NAME OF HOSPITAL OR INSTITUTION Good Samaritan Hospital Baltimore, Maryland 21212			C. CITY OR TOWN Cleveland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		8. DATE OF BIRTH 2/11/86	
13. FATHER'S NAME Frank Erb		14. MOTHER'S MAIDEN NAME Elizabeth Koch		9. AGE (In years last birthday) 84	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 285090106		17. INFORMANT Dr. Roy Scholz	
18. 410.941.350.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S. H.D.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus		(C) yes	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 2/11/70 19 to 4/8/70 19, that (I) was lost saw the deceased alive on 4/8/70 19 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE IA Orer m.d.				23B. DATE SIGNED 4/8/70	
23C. PHYSICIAN'S NAME (Type) I. Avni Orer M.D.				23D. ADDRESS Good Samaritan Hospital Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 4/11/70		24C. NAME of CEMETERY or CREMATORY Calvary	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Sabin, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
24D. LOCATION (City, town, or county) Cleveland		24E. LOCATION (State) Ohio		25D. ADDRESS 4905 York Rd Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-254 70 3774				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 1701 3774	
1. NAME OF DECEASED (Type or Print) McMULLEN, John J.				2. DATE AND HOUR OF DEATH 4/6/70 7:55 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Allegany C. CITY OR TOWN Cumberland D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 218 Fayette Street 21502			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/17/01		9. AGE (In years lost birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Publisher		10B. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hugh McMullen				14. MOTHER'S MAIDEN NAME Anna M. Mullady			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Louise Mc Mullen, Cumberland, Md. Wife			
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410.9 I ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. ASCVD pulmonary edema, CHF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). REFRACTORY HEART FAILURE							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from APRIL 3 1970 to APRIL 6 1970 , that (I) (we) last saw the deceased alive on APRIL 6, 7:50 PM 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harvey G. Klein				23B. DATE SIGNED 4/6/70		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Harvey G. Klein, M.D.				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 10, 1970		24C. NAME OF CEMETERY or CREMATORY SS. Peter & Paul Cem.		24D. LOCATION (City, town, or county) (State) Cumberland, Allegany, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. <u>B-425 70 3775</u>					CERTIFICATE OF DEATH					REG. NO. <u>70 3775</u>				
1. NAME OF DECEASED (Type or Print) <u>JOHN FREDERICK BELSCHNER</u>					2. DATE AND HOUR OF DEATH <u>4/5/70</u> <u>1.45 P.M.</u>									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2798</u>									
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI</u>					C. CITY OR TOWN <u>Baltimore</u>					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER <u>4901 Litchfield Ave #15</u>									
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-4-1886</u>		9. AGE (In years last birthday) <u>83</u>		10. Under 1 Yr. Months		11. Under 24 Hrs. Days		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>John F. Belschner</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>12-1-9398</u>					17. INFORMANT <u>Linnie E. Belschner - Same</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease or complication which caused death.) <u>Broncho pneumonia</u>					CAUSE OF DEATH A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerosis Heart disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Fracture of hip</u>					B. DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerosis Hypertension</u>					C. <u>9 months</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Fracture of hip</u>										<u>2 weeks</u>				
19A. DATE OF OPERATION <u>3/3/70</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fractured Hip</u>					20A. AUTOPSY? (Yes or No) <u>YES</u>				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>4901 Litchfield Ave, Balto-15146</u>					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>3 23 70 944</u>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				
21F. HOW DID INJURY OCCUR? <u>FELL GETTING OUT OF BED</u>					22. I certify that (I) (this hospital) attended the deceased from <u>March 23</u> 19 <u>70</u> to <u>April 5</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>April 5</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Manuel Levin</u>					23B. DATE SIGNED <u>4/5/70</u>					23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u>				
23D. ADDRESS <u>6101 PARK HEIGHTS AVE, BALTIMORE, MD 21215</u>					24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>					24B. DATE <u>4-9-70</u>				
24C. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE Cemetery</u>					24D. LOCATION (City, town, or county) (State) <u>Randallstown, Md</u>					25A. DATE REC'D BY HEALTH DEPT. <u>APR 9 1970</u>				
25B. NAME OF REGISTRAR <u>John E. Taylor</u>					25C. FUNERAL DIRECTOR <u>Armacost Funeral Chapel-4600 Liberty Hs</u>					25D. ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3776 ✓	
<div style="display: flex; justify-content: space-between;"> D-5351 70 3776 (DEMIDENKO) CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Patricia c. Demidenko			2. DATE AND HOUR OF DEATH 4/7/70 4/4/70 12:30 AM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital			A. STATE Maryland B. COUNTY Baltimore City/02		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 629 S. LINWOOD AVE #24					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/70	9. AGE (In years lost birthday) 6 weeks + 14	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10B. KIND OF BUSINESS OR INDUSTRY NONE.	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Demidenko			14. MOTHER'S MAIDEN NAME Patricia Fayer same.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Father & chart		ADDRESS
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 781.71 Respiratory arrest (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Encephalopathy? etiology (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/30 19 70 to 4/7 19 70 , that (I) (we) last saw the deceased alive on 4/7 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dan M. Granoff, M.D.				23B. DATE SIGNED 4/7/70	
23C. PHYSICIAN'S NAME (Type) DAN GRANOFF, M.D.				23D. ADDRESS Johns Hopkins Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/9/70		24C. NAME OF CEMETERY or CREMATORY ST. ANDREWS R.O. CEM. BALTO. COUNTY, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Ruth E. Taylor #2		25C. FUNERAL DIRECTOR W. FIALKOWSKI - 2007 EASTERN AVE.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3777	
BIRTH NO. 70 3777		1. NAME OF DECEASED (Type or Print) CHARLES RICHTER		2. DATE AND HOUR OF DEATH 4-7-70 10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL 43			A. STATE MD B. COUNTY —		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1 Talbot St.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-87	9. AGE (In years last birthday) 83	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY B&O Railroad		11. BIRTHPLACE (State or foreign country) BALTO. MD	
13. FATHER'S NAME GEORGE Richter			14. MOTHER'S MAIDEN NAME CHARLOTTE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-07-9481-8		17. INFORMANT WIFE ADDRESS SAME	
18. 395.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC TAMPONADE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 DAYS		
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (A) ADDUC STENOSIS C.H.F.; INTRA PERICARDIAL HEMORRHAGE (B) DUE TO, OR AS A CONSEQUENCE OF: (B) AORTIC STENOSIS; PERICARDIOCENTESIS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 14-7-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SUSPECTED PERICARDIAL DISEASE		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (N) (this hospital) attended the deceased from 3/28 19 70 to 4/7 19 70 that (N) (we) last saw the deceased alive on 4/7 19 70 and that (N) (my) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William Eric Sohn, M.D.			23B. DATE SIGNED 4-7-70		
23C. PHYSICIAN'S NAME (Type) OEGREE			23D. ADDRESS H402 COLBORNE RD #1 Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/11/70		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
				24D. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME of REGISTRAR Robert E. Sauer, M.D.		25C. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hgy. Baltimore, Md. 21225	

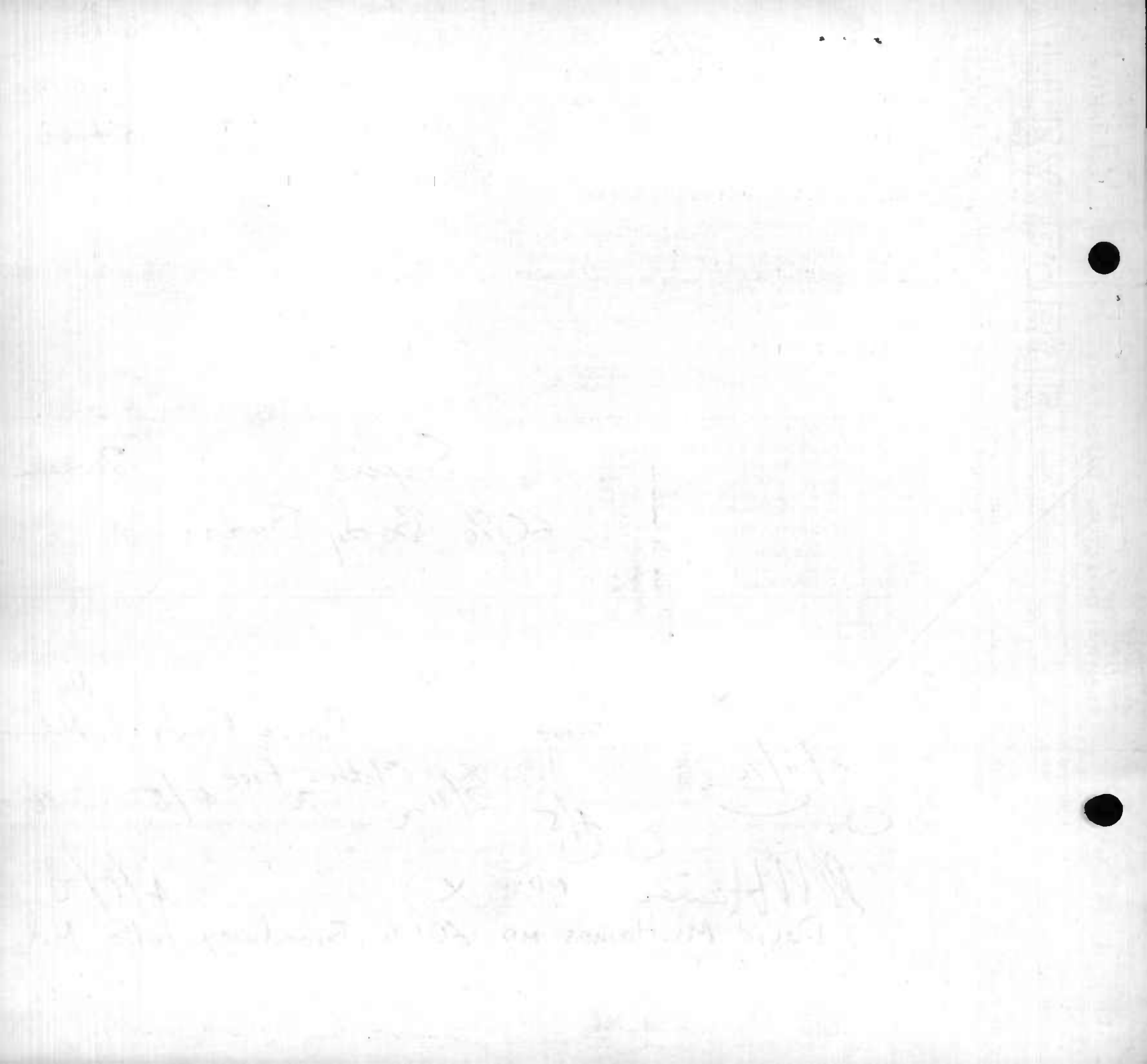


M.E.'S OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300 79 3778				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3778	
BIRTH NO. <i>229</i> 3778				1. NAME OF DECEASED (Type or Print) JACQUELINE BOYD		2. DATE AND HOUR OF DEATH 04-05-70 7:45 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>23</i> THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY CALVERT C. CITY OR TOWN PRINCE FREDERICK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box 149		5. AGE (In years last birthday) 5	
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-24-65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland Cal.	
13. FATHER'S NAME ALBERT RICE				14. MOTHER'S MAIDEN NAME BERNICE BOYD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Bernice Boyd Prince Frederick-Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Sepsis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>60% Body Burn</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 weeks</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Prince Frederick, Md.</i>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>2/11/70 7:30 A</i>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Clothes Fire</i>		22. I certify that (I) (this hospital) attended the deceased from <i>2/11</i> 19 <i>70</i> to <i>4/5</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>4/5</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>David M. Haines</i> MD DEGREE Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED <i>4/5/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>David M. Haines MD</i>		23D. ADDRESS <i>601 N. Broadway, Balto. Md.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>4-9-70</i>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <i>Carroll's Ch.. Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Barstow Cal. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 9 1970</i>		25B. NAME OF REGISTRAR <i>John E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Pinkey E. Sewell Prince Fred, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-431 70 3779				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3779	
1. NAME OF DECEASED (Type or Print) Elizabeth A. Kilduff				2. DATE AND HOUR OF DEATH 4/3/1970			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1661 Argonne Drive				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1661 Argonne Drive			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1885	9. AGE (In years lost birthday) 84	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bormuth				14. MOTHER'S MAIDEN NAME Catherine Grossman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 717-07-7658		17. INFORMANT ADDRESS Mrs. Thelma C. Schultz 1661 Argonne Drive			
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 10 1970 to 4.3. 1970 , that (I) (we) last saw the deceased alive on 4.3. 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE E. Ellsworth Cook				23B. DATE SIGNED 4-5-70		23C. PHYSICIAN'S NAME (Type) DR. E. ELLSWORTH COOK	
23D. ADDRESS 2431 MARYLAND AVE.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/7/70		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Belair Rd. Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Miller		25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd. BALTO., Md. 21212			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3780	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Attwood F. Blunt		2. DATE AND HOUR OF DEATH 4/5/1970 5:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 LONG GREEN NURSING HOME 115 E. Melrose Ave		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3010 Guilford Ave			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/15/1905	9. AGE (In years lost birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY C&P Tel. Co.		11. BIRTHPLACE (State or foreign country) Granite, Md.	
13. FATHER'S NAME Attwood Blunt			14. MOTHER'S MAIDEN NAME Emma Doughty		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-0818		17. INFORMANT ADDRESS Miss Emily Blunt 3010 Guilford Ave	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE Metastatic Brain tumor DUE TO, OR AS A CONSEQUENCE OF: (B) Bronchogenic Ca. DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/1/1970 to 4/5/1970 that (I) (we) last saw the deceased alive on 4/3/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.					
23A. SIGNATURE Norman R. Freeman				23B. DATE SIGNED 4/6/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
NORMAN R. FREEMAN		11 W. 29th St			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4/8/1970		Blunt Family Burial Ground	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 9 1970		Robert E. Taylor		Mitchell Wiedefeld Home	
ADDRESS				ADDRESS	
BALTO. MD. 21212				6500 York Rd. BALTO. MD. 21212	

0312

one hour

June 1, 1964

Subject

Reference

EXHIBIT 100-1-312

on 100-1-312

and 100-1-312

100-1-312

100-1-312

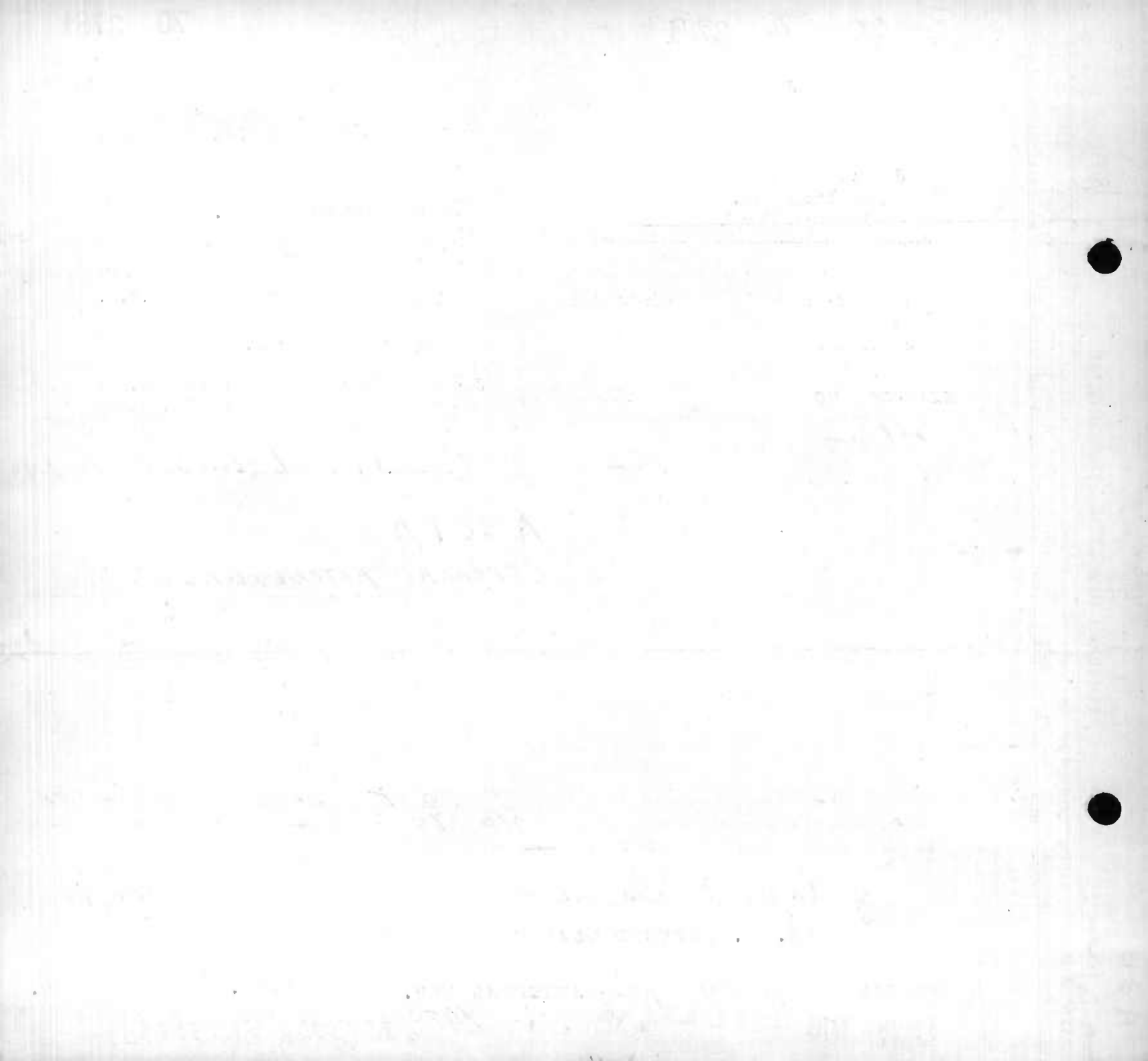
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 8-000 70 3781 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 70 3781	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) Miss Josie Shea		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 4/6/70 1:45 P. M. </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.5em;">91</div> Jenkins Memorial Hospital 1000 Caton Ave. Baltimore, Maryland 21229		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex;"> <div style="flex: 1;"> A. STATE Md. </div> <div style="flex: 1;"> B. COUNTY XXXXX MARYLAND XXXXX </div> </div>	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2823 GUILFORD AVE.		1203	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/1890
9. AGE (In years lost birthday) 79		10. Under 1 Yr. Months: ____ Ooys: ____ If Under 24 Hrs. Hours: ____ Min. ____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10B. KIND OF BUSINESS OR INDUSTRY Educational	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Shea		14. MOTHER'S MAIDEN NAME Mary Ann Fitzgerald	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-40-5588	
17. INFORMANT Jenkins Memorial		ADDRESS 1000 Caton Ave. Baltimore, Md. 21229	
18. 412.4 I CAUSE OF DEATH <div style="display: flex;"> <div style="flex: 1;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="flex: 1;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident </div> <div style="flex: 1;"> (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="flex: 1;"> (C) CEREBRAL ARTERIOSCLEROSIS </div> </div>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that 44 (this hospital) attended the deceased from 10/1/70 to 4/6/70 and that 44 (we) last saw the deceased alive on 4/6/70 and that in 44 (our) opinion death occurred on the date and hour and from the causes stated above, 44 (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. Raymond Gladue		23B. DATE SIGNED 4/6/70	
23C. PHYSICIAN'S NAME (Type) DR. J. RAYMOND GLADUE		23D. ADDRESS 6500 YORK RD-21212	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/8/70	
24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.		24D. LOCATION (City, town, or county) (State) BALTO, MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR MITCHELL WIEDEFELD HOME		ADDRESS 6500 YORK RD-21212	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3782

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD WITHERSPOON

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
4 6 1970 4:45 AM5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 13036. SEX Male 7. RACE Negro 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH July 6, 1913 10. AGE (In years lost birthday) 56 11. BIRTHPLACE (State or foreign country) Darlington S.C. 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME Carey Witherspoon

14A. USUAL OCCUPATION (Give kind of work during last of working life, even if retired) Welder 14B. KIND OF BUSINESS OR INDUSTRY Shipyard 15. MOTHER'S MAIDEN NAME Alice Sordens

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 17. SOCIAL SECURITY NO. 18. INFORMANT Elise Hill 2536 Francis St

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

20. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes

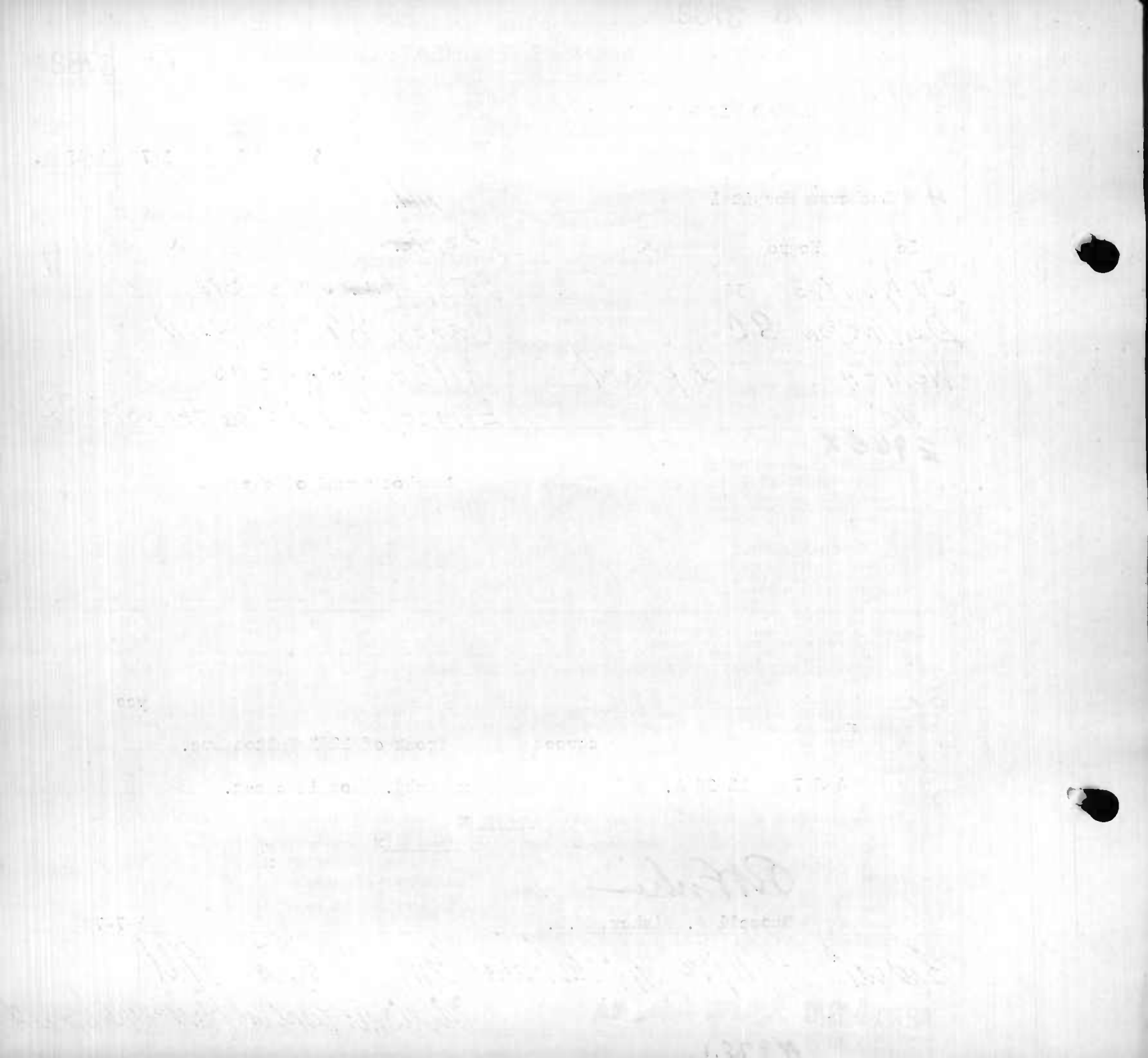
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) front of 2263 Fulton Ave. 1303

22D. TIME (Month) (Day) (Year) (Hour) 4-6-70 12:30 A.M. 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? Subj. Shot in chest.23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 4-7-70

24A. BURIAL-CREATION, REMOVAL (Specify) Burial 24B. DATE 4/11/70 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. Balto. Md. 24D. LOCATION (City, town or county) (State)

25A. DATE REC'D BY HEALTH DEPT. APR 10 1970 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. 25C. FUNERAL DIRECTOR Williams Funeral Home 399 N. Broadway

VS 151-REV. 1/1/68

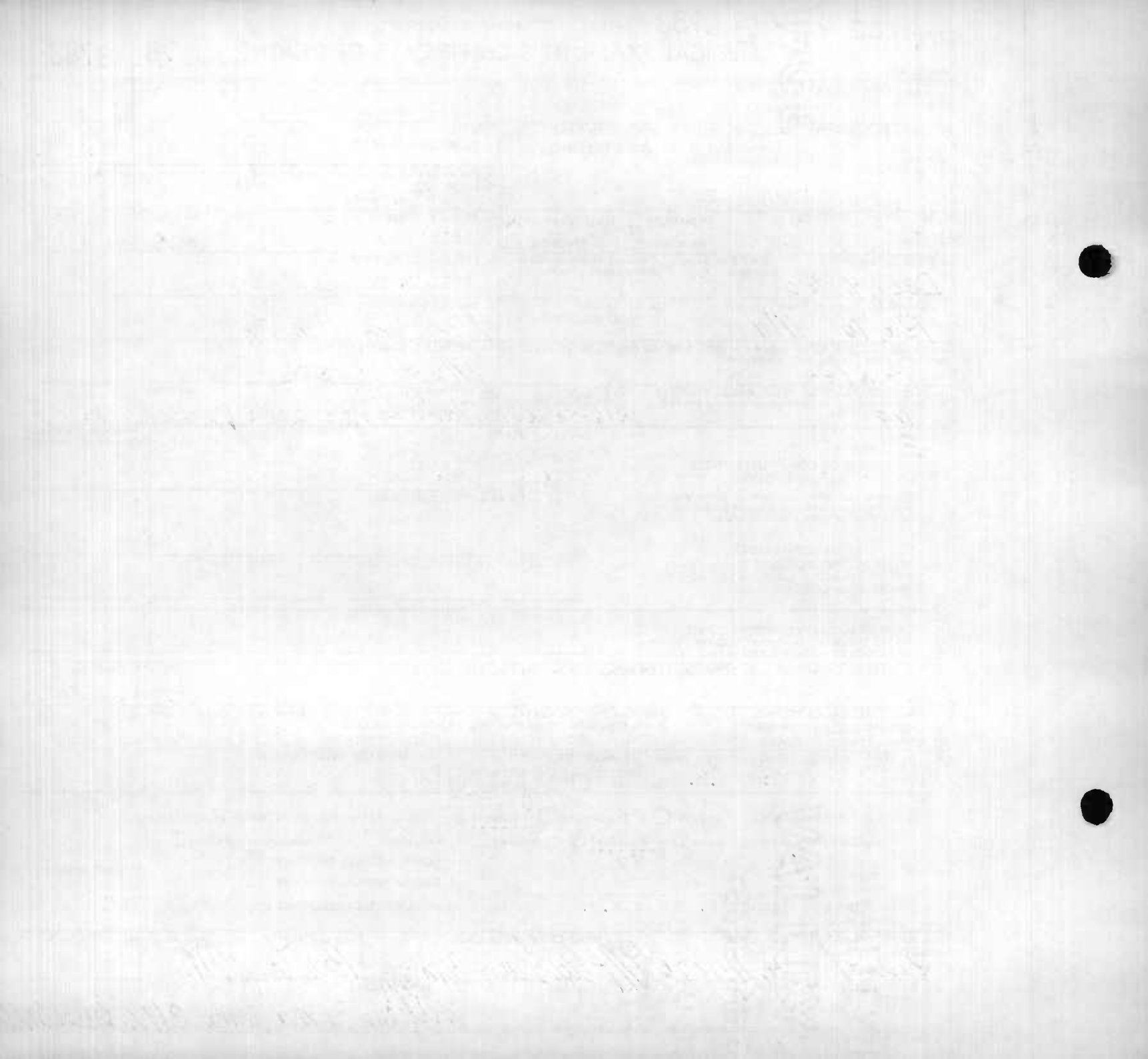


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3783

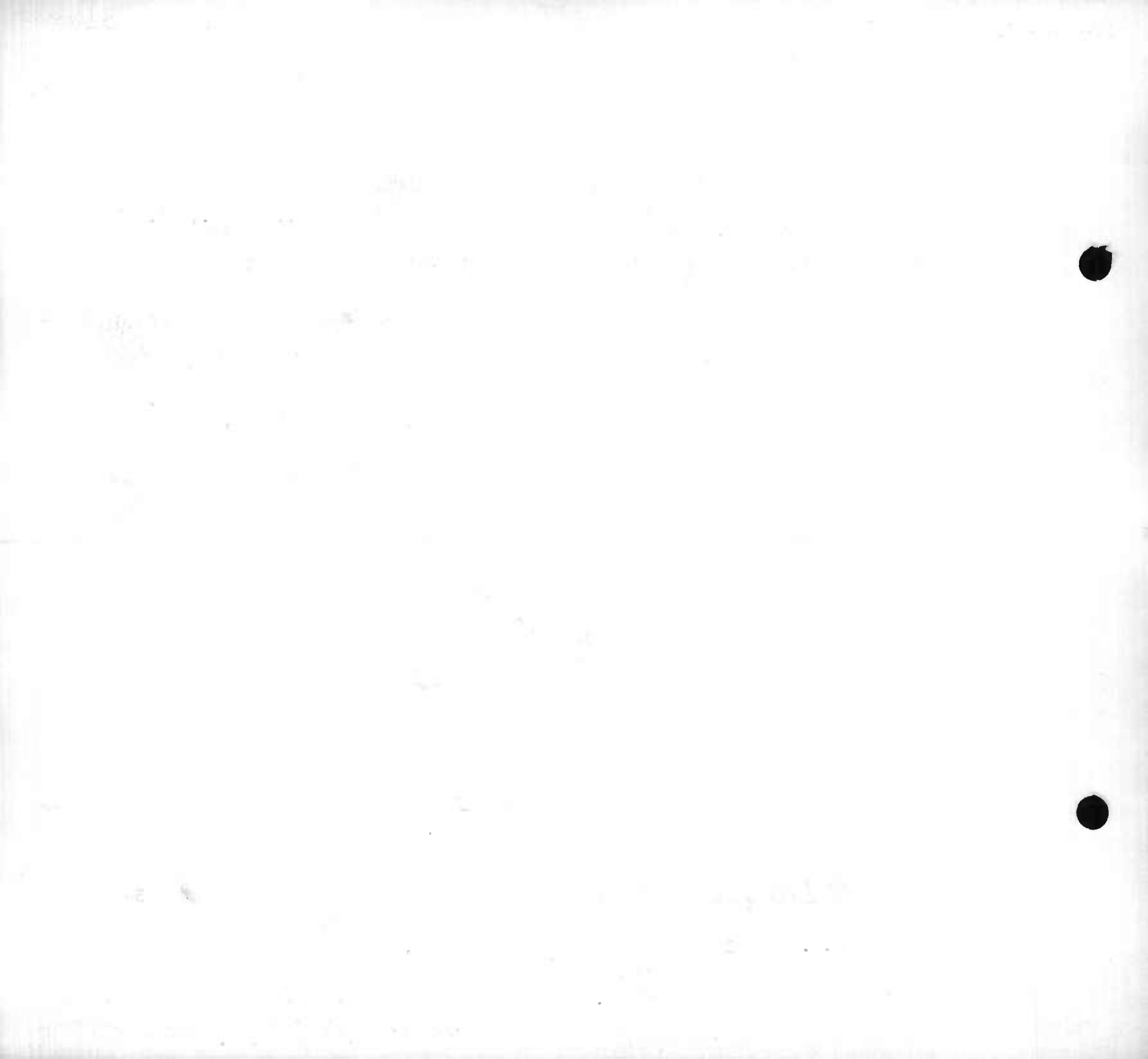
BIRTH NO.

1. NAME OF DECEASED (Type or Print) RONALD HICKS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 7, 1970 5:42 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2001	
9. DATE OF BIRTH Dec. 14, 1950		10. AGE (In years lost birthday) 19 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Theodore Smith		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer	
15. MOTHER'S MAIDEN NAME Mary Hicks		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 216-58-633		18. INFORMANT Mary Hicks	
19. E922.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Gunshot wound of Abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? In front of 2012 W. Lexington Street		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-6-70 1:00 A.M. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Accidentally shot	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/7/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/11/1970	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		25B. NAME OF REGISTRAR Robert E. Spitz, M.D.	
25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Schrodner St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

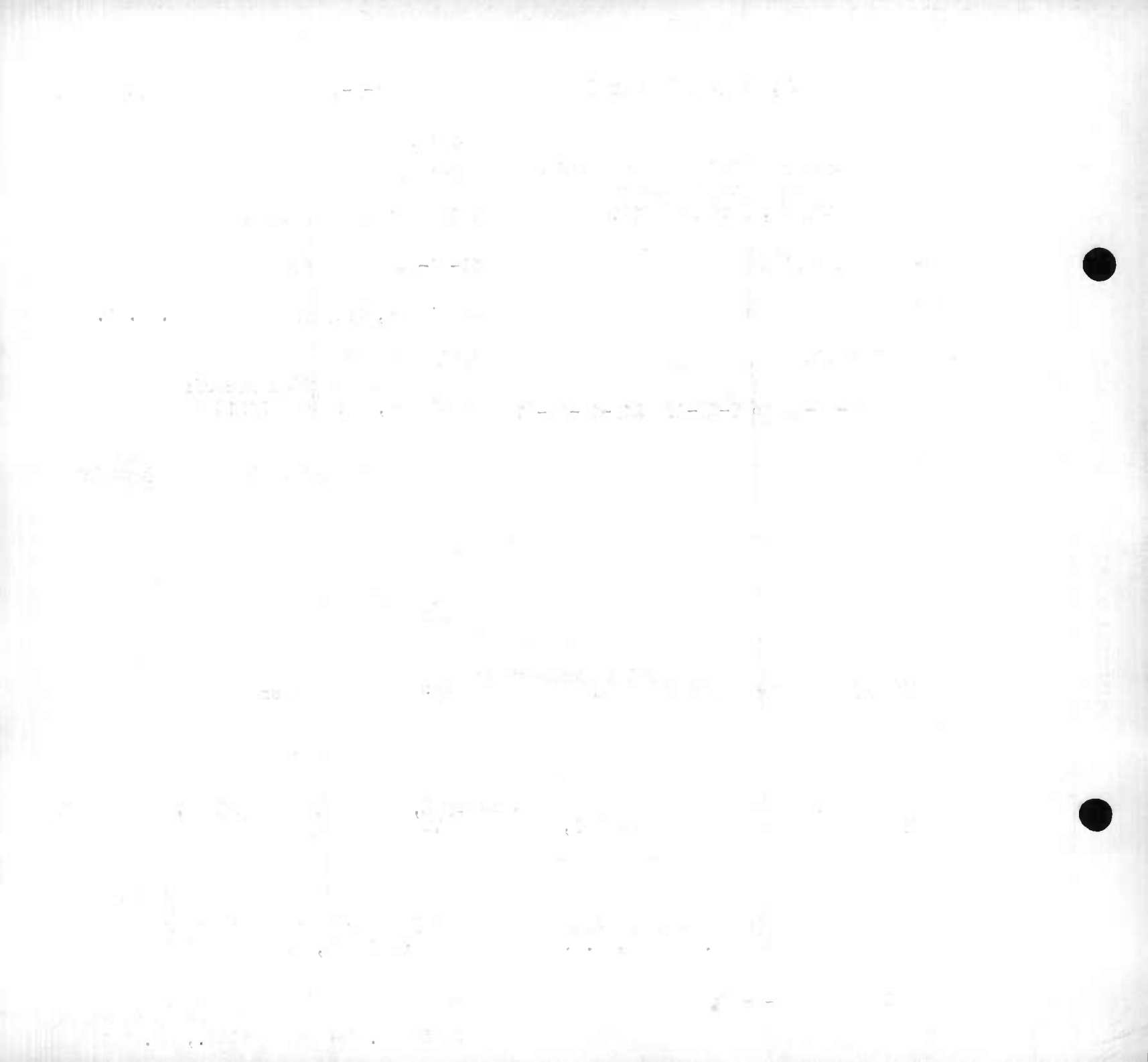
K-160		70 3784		BALTIMORE CITY HEALTH DEPARTMENT		70 3784	
BIRTH NO.		70 3784		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Olive Keefer</u>				2. DATE AND HOUR OF DEATH 4-5-70 11:15 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1513</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3503 Virginia Ave., Balto., Md. 21224</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-02</u>	9. AGE (In years lost birthday) <u>67</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>United States</u>
13. FATHER'S NAME <u>Bert D. Garner</u>				14. MOTHER'S MAIDEN NAME <u>Lydia J. Sisler</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>W2-389-846</u>			
17. INFORMANT <u>BCH Records: Baltimore, Maryland 21224</u>				ADDRESS <u>4940 Eastern Ave.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Huntington Chorea</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory arrest</u> (B) <u>Sepsis</u> (C) <u>pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>2 day</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (it) (this hospital) attended the deceased from <u>1-25</u> 19 <u>63</u> to <u>4-5</u> 19 <u>70</u> that (it) (we) last saw the deceased alive on <u>4-5</u> 19 <u>70</u> and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (it) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J.R. Brechtel MD</u>				23B. DATE SIGNED <u>4-5-70</u>		23C. PHYSICIAN'S NAME (Type) <u>J.R. Brechtel</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-8-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Chartiers Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pittsburg, Penna.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Collins</u>		25C. FUNERAL DIRECTOR <u>F. J. Collins</u>		ADDRESS <u>500 University Blvd. W. Silver Spring, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

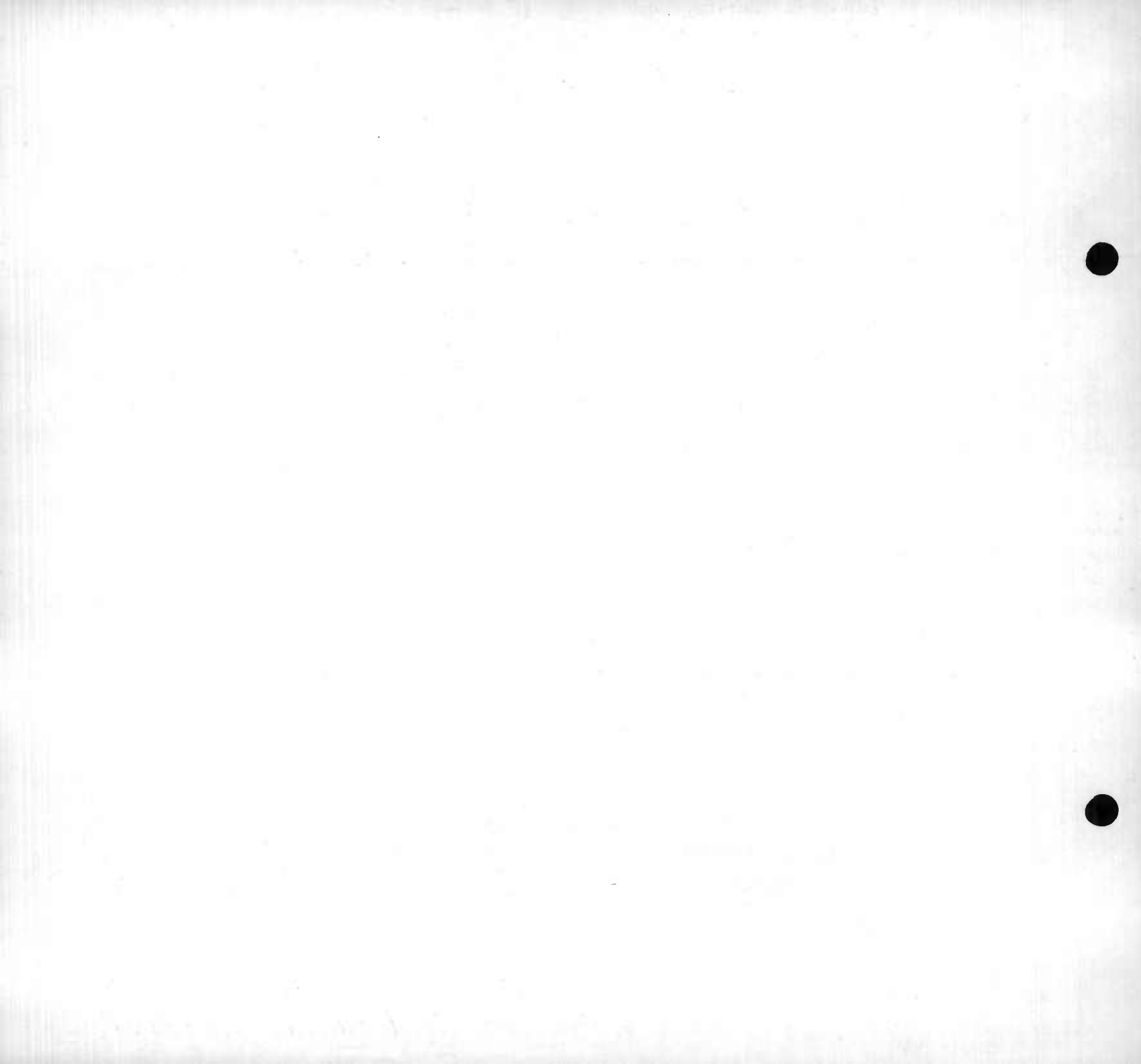
Baltimore City Health Department				REG. NO. 70 3785	
E-165 70 3785					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) EBERWEIN, Christopher Fred			2. DATE AND HOUR OF DEATH 4-3-70 1:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 3900 Loch Raven Boulevard Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1903		
5. SEX Male			6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 11-21-06 9. AGE (In years last birthday) 63 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
13. FATHER'S NAME Jacob Eberwein			14. MOTHER'S MAIDEN NAME Katie Newcome		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7-28-42 to 9-29-45			16. SOCIAL SECURITY NO. 213-10-39-61		17. INFORMANT VA Hospital Records ADDRESS Baltimore, Maryland 21218
18. 436.9 + 1 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Cerebral vascular accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus Duodenal ulcer			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 2/10/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED partial gastrectomy		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 3/12/70		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that II (this hospital) attended the deceased from January 2, 19 70 to April 3, 19 70 and that ID (we) last saw the deceased alive on April 3, 19 70 and that ID (our) opinion death occurred on the date and hour and from the causes stated above. II (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald H. Hooker DONALD H. HOOKER, M.D.			23B. DATE SIGNED 4/6/70		23C. PHYSICIAN'S NAME (Type) DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4-7-70		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery
25A. DATE REC'D BY HEALTH DEPT. APR 10 1970			25B. NAME OF REGISTRAR William E. Johnson		25C. FUNERAL DIRECTOR Baltimore Maryland 8521 Loch Raven Blvd Balto., Md. 21204



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-620 70 3786				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3786	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Rose Mark		April 3 70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
003116 Northern Ave.				Md		2735	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Balt		YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3116 Northern Ave			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
7	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct 30 86	84	83		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None				Balt			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				John Bernickel		3116 Northern Ave	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 2-13-1960 to 4-2-1970, that (I) (we) last saw the deceased alive on 4-2-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Sebastian Russo				4/6/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
SEBASTIAN RUSSO				5017 Harford Rd			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/1		Sacred Heart		German Hill Rd Balto	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 10 1970		Robert E. Taylor, M.D.		J. W. Wynn		6067 Hayfield	



FUNERAL DIRECTOR: IMPORTANT

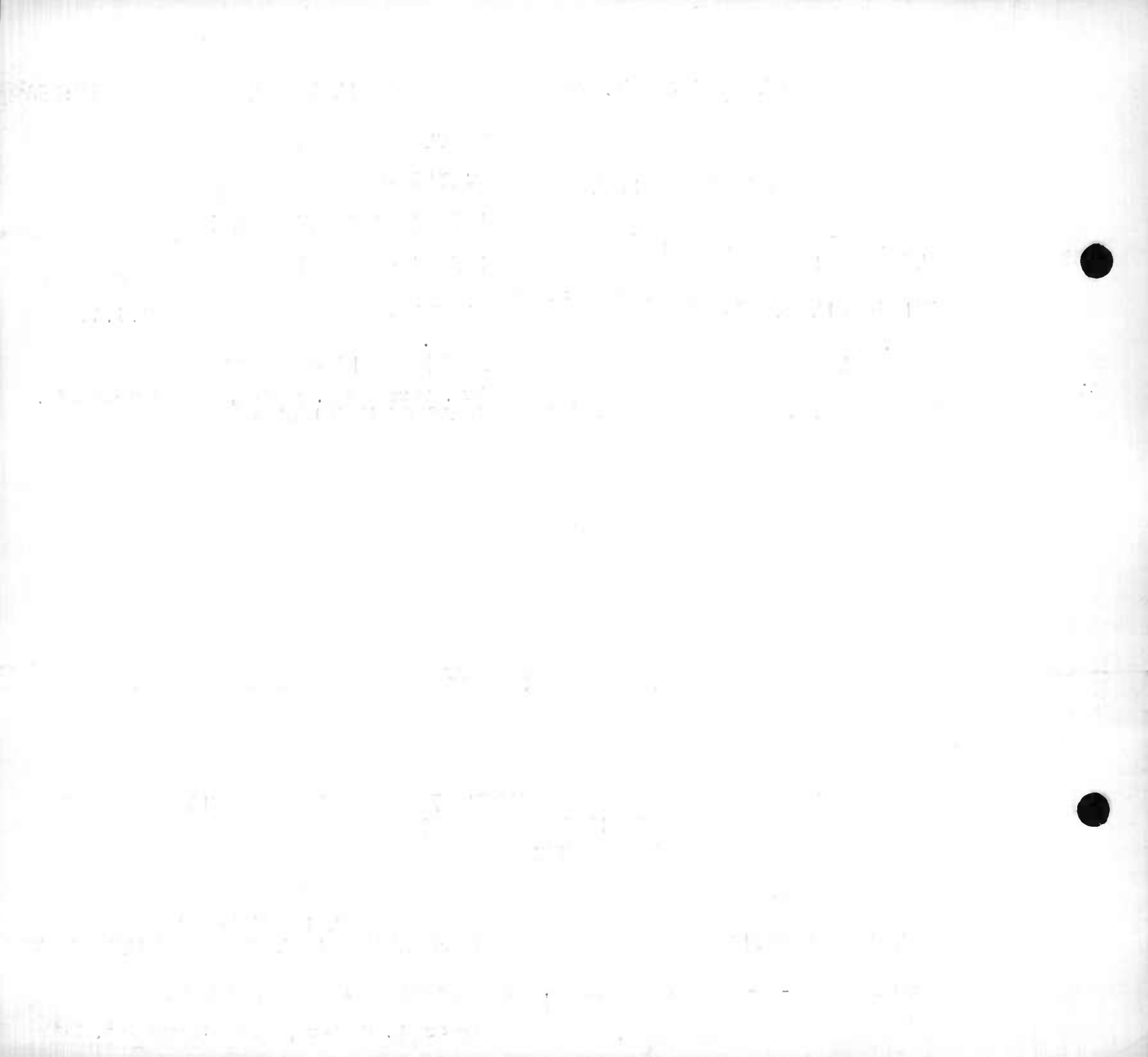
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3787</u>	
BIRTH NO. <u>S-655 70 3787</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Sherman, Bessie Bernette</u>		2. DATE AND HOUR OF DEATH <u>4-8-70 8:45 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Md. Hospital</u>		C. CITY OR TOWN <u>BALTO, Md 21223</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ADDRESS OR LOCATION <u>Redwood & Greene Sts.</u>		E. STREET AND NUMBER <u>1144 Sergeant St. - 21223</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-2-94</u>	9. AGE (in years lost birthday) <u>75</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Oliver Briggs</u>		14. MOTHER'S MAIDEN NAME <u>Addie May Geimes</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Lemo Buckler - 1307 W. Cross St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PERITONITIS</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PERITONITIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ruptured appendicitis</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>OLD AGE - A.S.V.D</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>OLD AGE</u>					
19A. DATE OF OPERATION <u>3/31/1970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RUPTURED APPENDICITIS</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/30</u> 19 <u>70</u> to <u>4/8</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/8/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Karas</u>		DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/8/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>KARAS A. C.</u>		23D. ADDRESS <u>UNIV. HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/11/1970</u>		24C. NAME of CEMETERY or CREMATORY <u>Linden Park Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Conner & Son, Inc.</u>	
ADDRESS <u>1001 Hollings St. Balto. Md.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

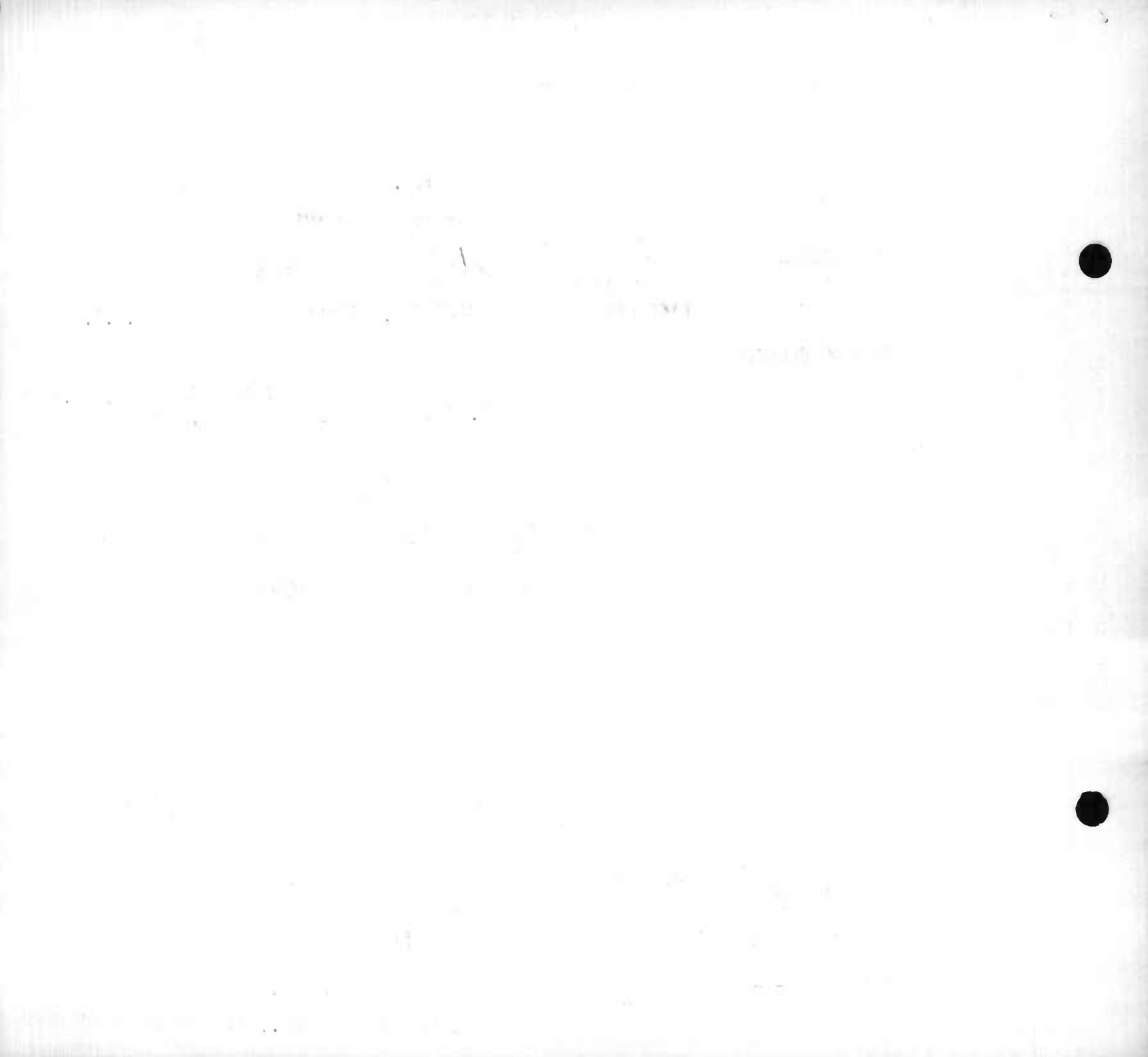
M-450		70 3788		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3788	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MOYLAN, FRANK D. SR				2. DATE AND HOUR OF DEATH APRIL 7, 1970 10:25 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARYLAND B. COUNTY BALTO				5. CITY OR TOWN CATONSVILLE MANOR			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		C. CITY OR TOWN				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1110 GREGORY AVE 21207		6. DATE OF BIRTH 10/22/98				7. AGE (in years last birthday) 71		8. If Under 1 Yr. Months: Days: Hours: Min.	
9. SEX MALE		10. RACE WHITE		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BIRTHPLACE (State or foreign country) MARYLAND		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED OIL BURNER		10B. KIND OF BUSINESS OR INDUSTRY Bryant Oil Heating		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME J. JOHN MOYLAN	
14. MOTHER'S MAIDEN NAME MARY (NEE DIGNAN) MOYLAN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.1		16. SOCIAL SECURITY NO. 212032768		17. INFORMANT Mrs. Caroline R. Moylan, 1110 Gregory Ave. ST AGNES HOSPITAL RECORDS		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I TUMORAL CAELEXIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: DISEMINATED CARCINOMATOSIS (B) DUE TO, OR AS A CONSEQUENCE OF: Adeno Ca Left Lung - (C) Prostatic Hy per trophy -		19. CAUSE OF DEATH		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		22. MEDICAL CERTIFICATION	
23. DATE OF OPERATION 0		24. CONDITION FOR WHICH OPERATION WAS PERFORMED		25. AUTOPSY? (Yes or No) NO		26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		27. MEDICAL CERTIFICATION	
28. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		31. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		32. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
33. HOW DID INJURY OCCUR?		34. I certify that (I) (this hospital) attended the deceased from MARCH 27 1970 to APRIL 7 1970		35. that (I) (we) last saw the deceased alive on APRIL 7 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		36. 23A. SIGNATURE Alejandro Mejia		37. 23B. DATE SIGNED	
38. 23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA		39. 23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES		40. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial		41. 24B. DATE 4-10-1970		42. 24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
43. 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		44. 25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		45. 25B. NAME OF REGISTRAR Robert E. [Signature]		46. 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		47. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

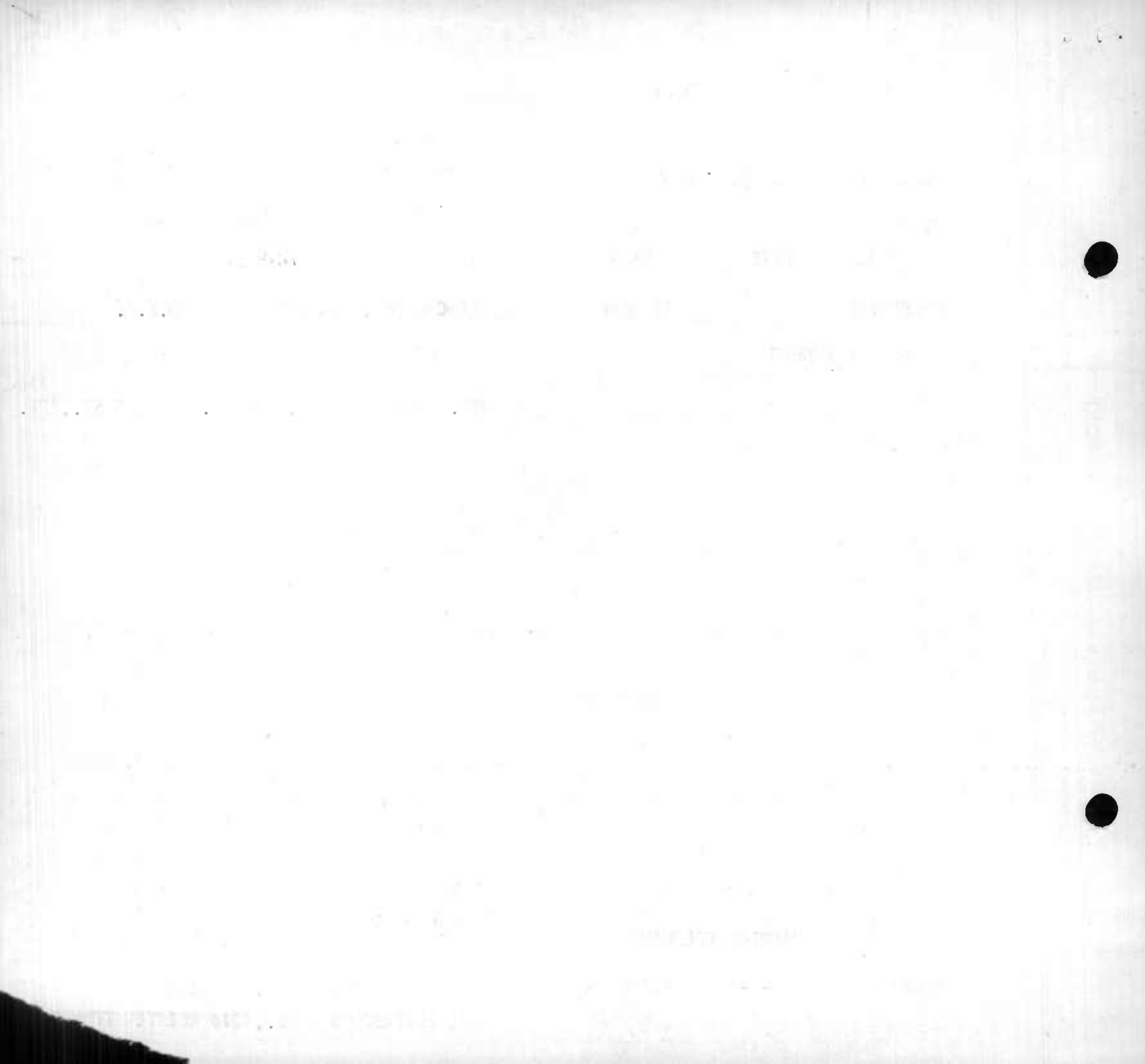
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3789	
C-525 70 3789		BIRTH NO.	
1. NAME OF DECEASED (Type or Print) CHENKIN, HERMAN		2. DATE AND HOUR OF DEATH 4/8/70 12:15 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai hospital		A. STATE MARYLAND B. COUNTY 2788	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE 6. RACE WHITE		E. STREET AND NUMBER 5301 NELSON AVENUE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/22/07 9. AGE (in years last birthday) 63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY TAXI CAB		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ABRAHAM CHENKIN		14. MOTHER'S MAIDEN NAME SOPHIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. JOEL CHENKIN, ALEXANDRIA, VIRGINIA 22311		ADDRESS 5001 SEMINARY ROAD, APT. 1412	
18. 193X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Multiple metastasis (carcinomatosis)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Mth	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Thyroid Adenocarcinoma		DUE TO, OR AS A CONSEQUENCE OF: 1 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). hyper Para Thyroidism		DUE TO, OR AS A CONSEQUENCE OF: ?	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2/28/70 19 to 4/8/70 19 that (I) (we) last saw the deceased alive on 4/8/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE R. Hoorazar 7068 M.D.		23B. DATE SIGNED 4/8/70	
23C. PHYSICIAN'S NAME (Type) R. HOORAZAR, M.D.		23D. ADDRESS Sinai hospital, MD 21215	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-9-70	
24C. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		25B. NAME OF REGISTRAR Robert E. ...	
25C. FUNERAL DIRECTOR SOE LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3790	
P-340 70 3790		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Pittle Esther</i>		2. DATE AND HOUR OF DEATH <i>4-6-70 8³⁰A</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>PLEASANT MANOR NURSING HOME</i> <i>90</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>21215</i> C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3321 Clarks Lane</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 17, 1900</i>	9. AGE (In years last birthday) <i>69</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>WINCHESTER, VIRGINIA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>SENDER FEINBERG</i>		14. MOTHER'S MAIDEN NAME <i>KATIE ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>MRS. FLORINE MACKS, 4000 N. CHARLES ST., APT. 1104</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <i>4/2/70</i> CAUSE OF DEATH <i>Cerebro vascular accident</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>arterial cerebral disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>5 yrs</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>II</i> <i>Broncho pneumonia</i>				3 days -	
19A. DATE OF OPERATION <i>none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/2 1964</i> to <i>4/6 1970</i> , that (I) (we) last saw the deceased alive on <i>4/6 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Maurice Feldman</i> DEGREE				23B. DATE SIGNED <i>4/6/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>MAURICE FELDMAN</i> DEGREE				23D. ADDRESS <i>6610 CROSS COUNTRY BLVD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-7-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>ANSHE EMUNAH</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 10 1970</i>		25B. NAME OF REGISTRAR <i>Robert F. Taylor</i>	
25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN</i>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3791	
F-453 70 3791		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) REBA FOLAND			2. DATE AND HOUR OF DEATH APRIL 7, 1970 12:15 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL 42			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6318 GREENSPRING AVENUE, APT. 107 #21209 2730		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-1897	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME BENJAMIN MASEROVITZ		
14. MOTHER'S MAIDEN NAME BERTHA ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT MR. LOUIS FOLAND, 6318 GREENSPRING AVE., APT. 107		
18. 410.94 150.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction (B) Arteriosclerosis (C) Diabetes mellitus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs. years. years.		
MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/7 19 70 to 4/7 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Morton E. Mower				23B. DATE SIGNED 4/8/70	
23C. PHYSICIAN'S NAME (Type) MORTON MOWER				23D. ADDRESS 200 W. COLD SPRING LANE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-9-70		24C. NAME OF CEMETERY or CREMATORY BETH JACOB	
24D. LOCATION (City, town, or county) (State) FINKSBURG, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 10 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) A physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 3792	
BIRTH NO. K-520 70 3792		1. NAME OF DECEASED (Type or Print) ANNA W. KNOEHE		2. DATE AND HOUR OF DEATH 4/7/70 1:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL 35 BALTIMORE, MARYLAND.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2610 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 114 S. HIGHLAND AVENUE		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9.30.88	9. AGE (In years last birthday) 81	10. UNDER 1 Yr. Months: Days: Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? AMERICAN		
13. FATHER'S NAME FREDERICK HOLSTE			14. MOTHER'S MAIDEN NAME MARY BUSHEIMER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 220-14-7390		
17. INFORMANT ERNEST KNOEHE, 20 DUNKIRK RD, 21212			ADDRESS		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). </div> <div style="width: 15%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div> <div style="margin-top: 10px;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest. </div> <div style="margin-top: 10px;"> (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD, Ac. MI, CHF </div> <div style="margin-top: 10px;"> (C) DUE TO, OR AS A CONSEQUENCE OF: atrial fibrillation </div>					
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/31 1970 to 4/7 1970 that (I) (we) last saw the deceased alive on 4/7 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A.C. Chouvalit, M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) A.E. CHOUVALIT, M.D.				23D. ADDRESS Church Home of Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-10-70		24C. NAME of CEMETERY or CREMATORY LORRAINE CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.		25A. DATE REC'D BY HEALTH DEPT. APR 10 1970 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR URLEICH FUNERAL HOME, BALTO, MD. 21206 ADDRESS			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3793

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEON RYCHWALSKI

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CITY HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

A.

April 7, 1970

6:24 A.

M.

5. USUAL RESIDENCE (Where deceased lived, if Institution; residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Nov 24-1923

10. AGE (In years
last birthday)

46

11. Under 1 Yr. 12 Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

6703 O'Donnell Street

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Phillip Rychwalski

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

/ ?

15. MOTHER'S MAIDEN NAME

Josephine Lemki

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Margaret Rychwalski 6703 O'Donnell Street

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Acute peritonitis

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Ruptured Viscus

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHOTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy
M.D.CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/7/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-9-1970

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

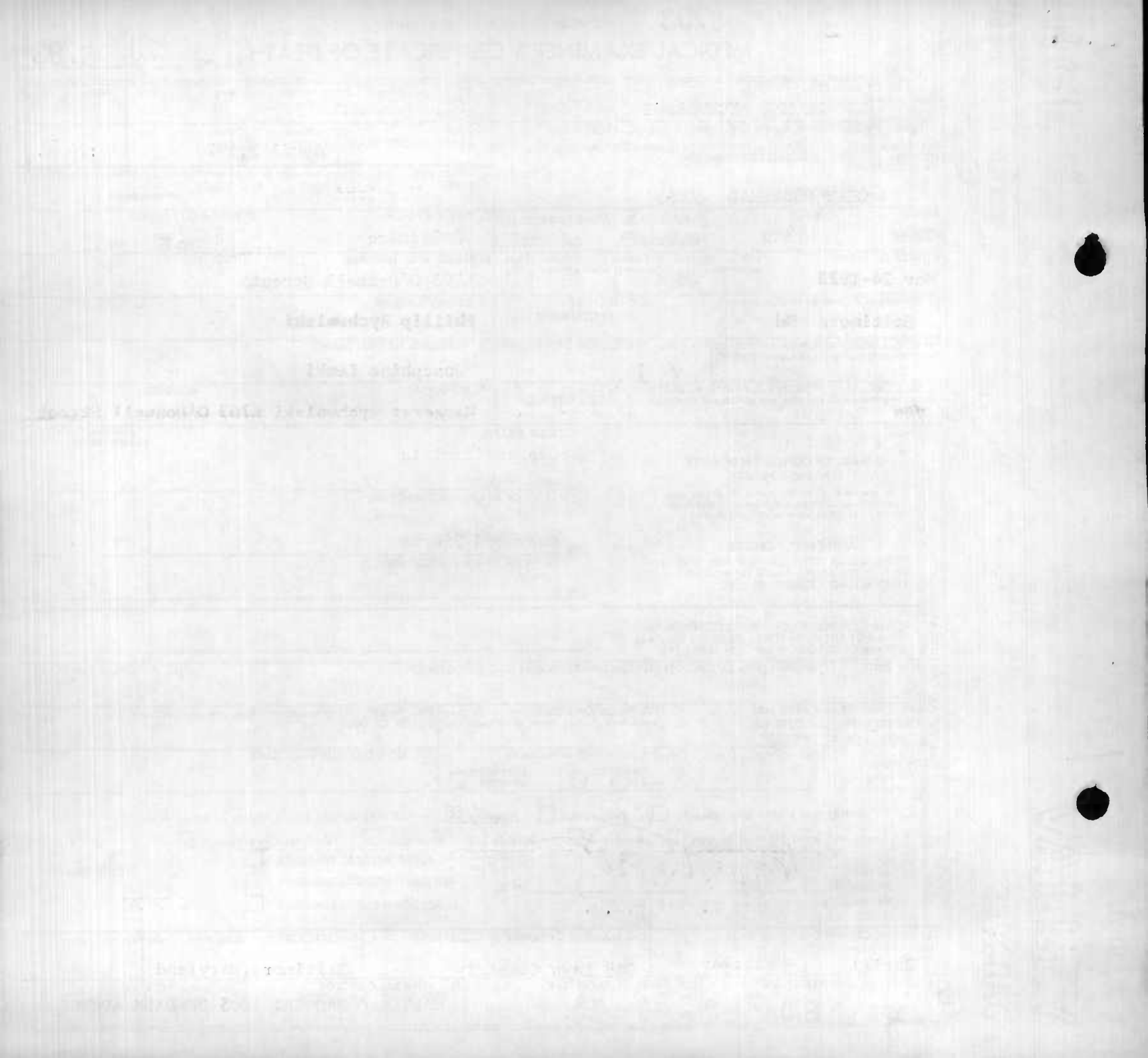
25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

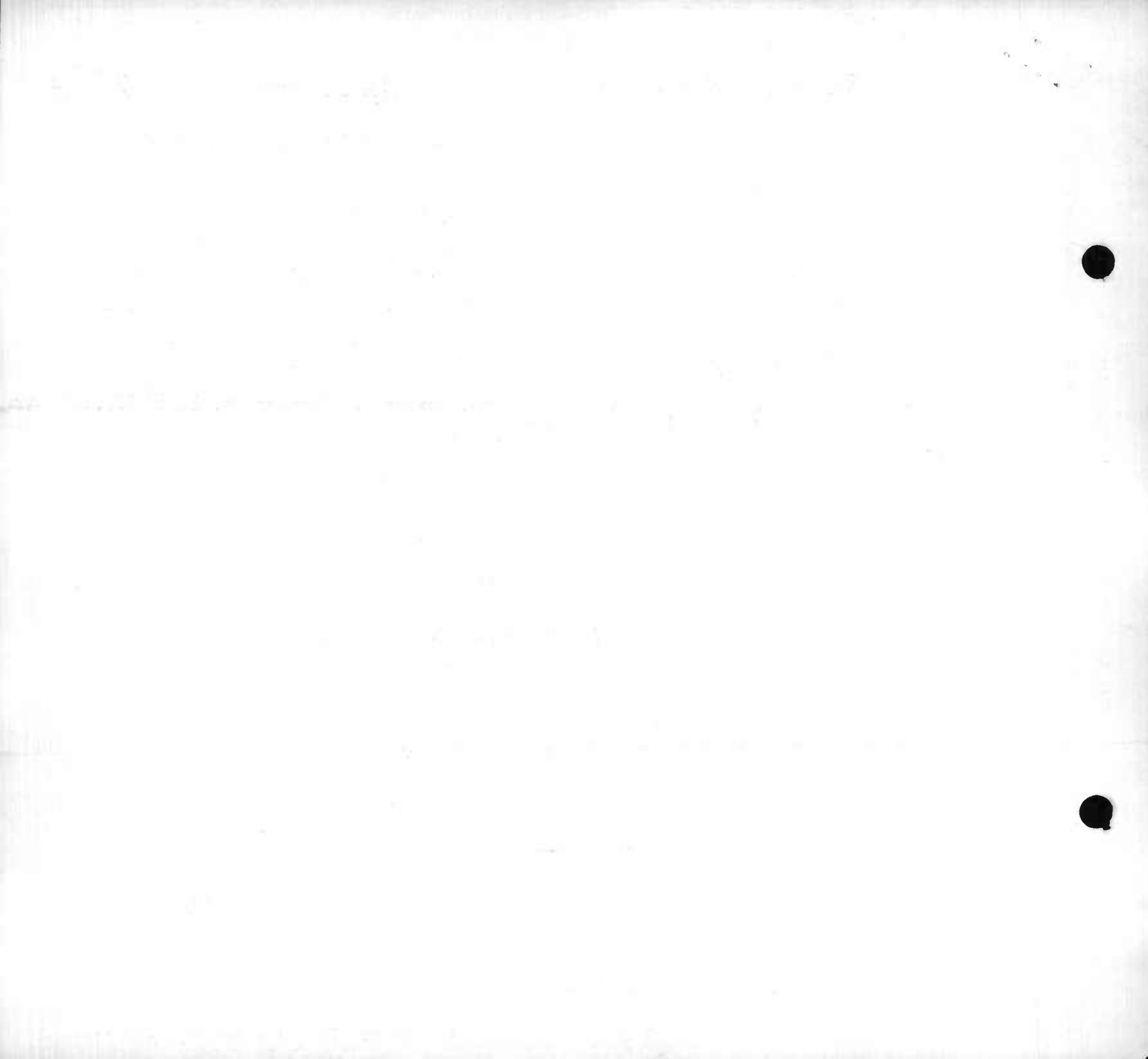
WALTER DABROWSKI 1001 DUNDALK AVENUE



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 3794</u>	
C-455 <u>70 3794</u>		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. <u>70 3794</u>		DATE AND HOUR OF DEATH <u>Apr 16, 1970</u> <u>7⁰⁷ A</u> M.	
1. NAME OF DECEASED (Type or Print) <u>Richard Clements</u>		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Senas Hospital</u>		A. STATE <u>Md.</u> B. COUNTY <u>Woodstock</u> Baltimore <u>5300</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Woodstock</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		E. STREET AND NUMBER <u>Rt. 1 Box 57</u>	
Student		10B. KIND OF BUSINESS OR INDUSTRY	
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2/24/56</u>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>14 yrs.</u>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Baltimore, Maryland		U.S.A.	
13. FATHER'S NAME <u>Clements, Roy</u>		14. MOTHER'S MAIDEN NAME <u>Martha West</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Martha A. Clements</u>		ADDRESS <u>Rt. 1 Box 57 Woodstock 21163</u>	
18. <u>354 X I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<u>Tracheal bleeding</u> <u>5 minutes</u>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		<u>Tracheostomy</u> <u>4 months</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		<u>Guillain-Barre Syndrome</u> <u>4 months</u>	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>T-E Fistula, GI bleeding</u>	
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>December 4</u> 19 <u>69</u> to <u>April 6</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>April 6</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Gary Racheletsky</u>		23B. DATE SIGNED <u>4/6/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>GARY Racheletsky</u>		23D. ADDRESS <u>550 North Broadway Balt, Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/10/70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Lake View Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Sykesville Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1970</u>	25B. NAME OF REGISTRAR <u>Deane, John</u>	25C. FUNERAL DIRECTOR <u>Loring Byers</u>	ADDRESS <u>8728 Liberty Rd. Randallstown</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3795	
F-260 70 3795		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARVIN FEGER		2. DATE AND HOUR OF DEATH 4 9 70 1:40 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 2 Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY USA C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8525 MARYBETH WAY			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/26/15	9. AGE (in years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Foreman		10B. KIND OF BUSINESS OR INDUSTRY Md. Trans. Co.		11. BIRTHPLACE (State or foreign country) Penn	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 6/22/42-7/19/45		17. INFORMANT Mrs. Frances Fleger, 8525 Marybeth Way	
18. 2070 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE Leukemia		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 3/31 19 70 to 4/9 19 70 that (1) (we) last saw the deceased alive on 4/9 19 70 and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. 1:40 PM					
23A. SIGNATURE P B Donovan		DEGREE		23B. DATE SIGNED 4/9/70	
23C. PHYSICIAN'S NAME (Type) P B Donovan		DEGREE		23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/11/70		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery	
24D. LOCATION Maryland		24E. NAME of REGISTRAR Robert E. Fieber		24F. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228	
25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



BIRTH NO.		REG. NO.	
H-400		70 3796	
BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
JAMES M. HOLLAWAY		Known <input type="checkbox"/> Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		3. DATE PRONOUNCED DEAD	
(If not in hospital or institution, give street address or location)		Month Day Year Hour	
33 Johns Hopkins Hospital		4 5 1970 8:30 A.M.	
6. SEX		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Male		A. STATE B. COUNTY	
7. RACE		C. CITY OR TOWN	
Negro		Balto.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		D. INSIDE CITY LIMITS?	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		E. STREET AND NUMBER	
4-1-51		1610 N. Washington St.	
10. AGE (In years lost birthday)		12. CITIZEN OF WHAT COUNTRY?	
19		U.S.A.	
11. BIRTHPLACE (State or foreign country)		13. FATHER'S NAME	
Balto., Md.		Fred Holloway	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
Nurse		Ruth Gearse	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
No		212-5K	
18. INFORMANT		ADDRESS	
Ruth Holloway		1610 N. Washington St.	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Intravenous narcotism	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
2			
21. AUTOPSY? (Yes or No)		yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
Russell S. Fisher, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		4-10-70	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Crown Point Park		Laurel, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
APR 10 1970		Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
Randolph J. Collick		2431 E. Oliver St.	

ACADEMY BOND

VALLEY BOND

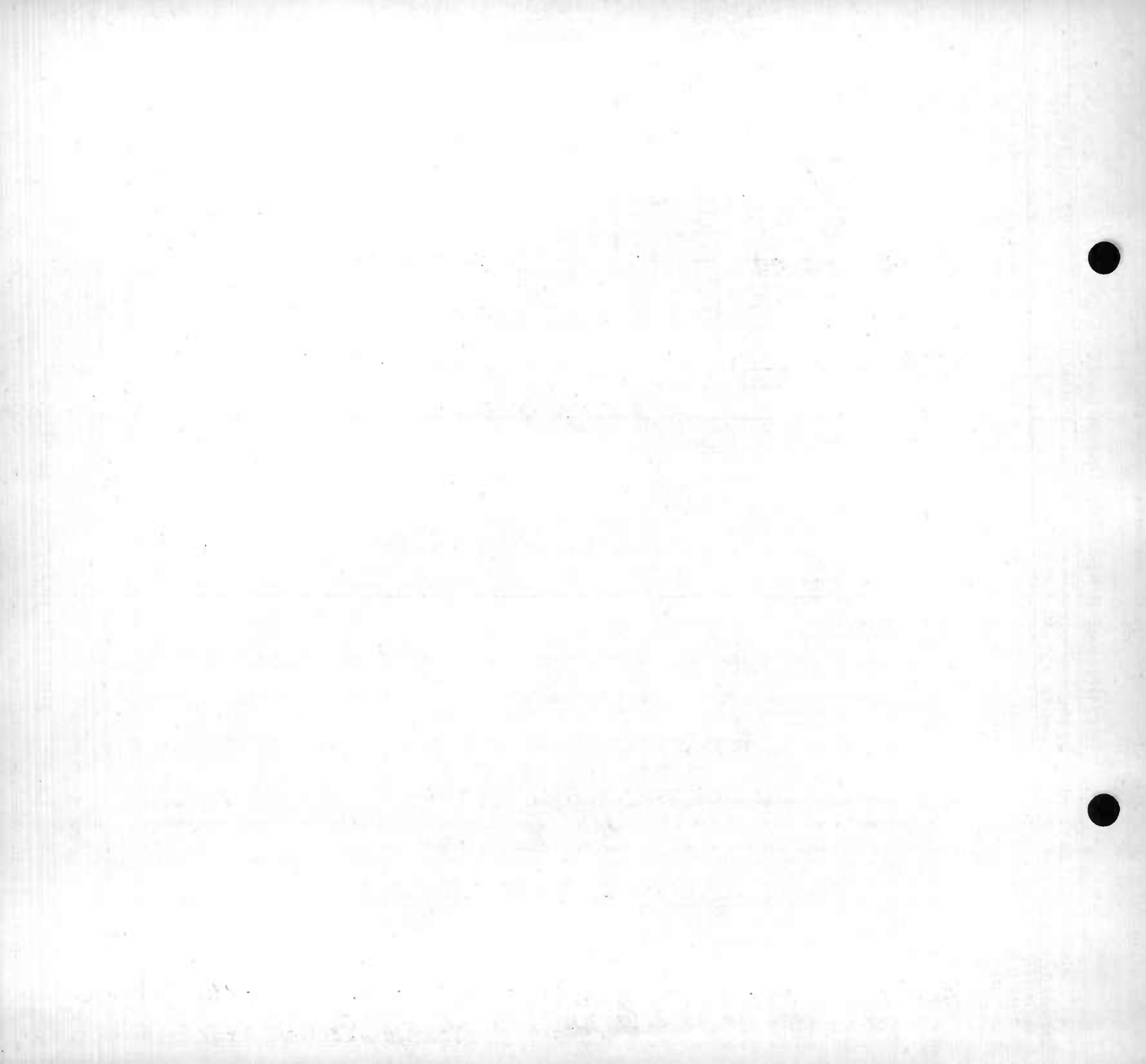
VALLEY BOND

BALTIMORE CITY HEALTH DEPARTMENT				AMENDED				4-20-70			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH								REG. NO. 70 3797			
BIRTH NO.											
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input checked="" type="checkbox"/> Month Day Year Hour							
Mabel Knight				4 4 70 1045 P.M.							
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year Hour				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
420 Mott St.				4 4 70 1102 P.M.				MD 501			
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Fem		Col				Baltimore					
9. DATE OF BIRTH			10. AGE (In years last birthday)			E. STREET AND NUMBER					
3-9-1903			69 67			420 Mott St.					
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
West Va.				U.S.A.				UNKNOWN			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY				15. MOTHER'S MAIDEN NAME			
Domestic								UNKNOWN			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.				18. INFORMANT ADDRESS			
No				112-18-9228				James C. Knight 420 Mott St.			
19. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)											
Hypertensive Cardiovascular Disease											
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:											
Vascular Disease											
(B) DUE TO, OR AS A CONSEQUENCE OF:											
(C) _____											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No)			
0								NO.			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				4.5.70			
Wetner				U. Spitz				ASSOCIATE MEDICAL EXAMINER			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial				4-9-70		Arbutus Memorial Park, Arbutus, Md.					
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
APR 10 1970				R. E. Fisher				Rudolph J. Collick 2431 E. Oliver St.			

FUNERAL DIRECTOR: IMPORTANT

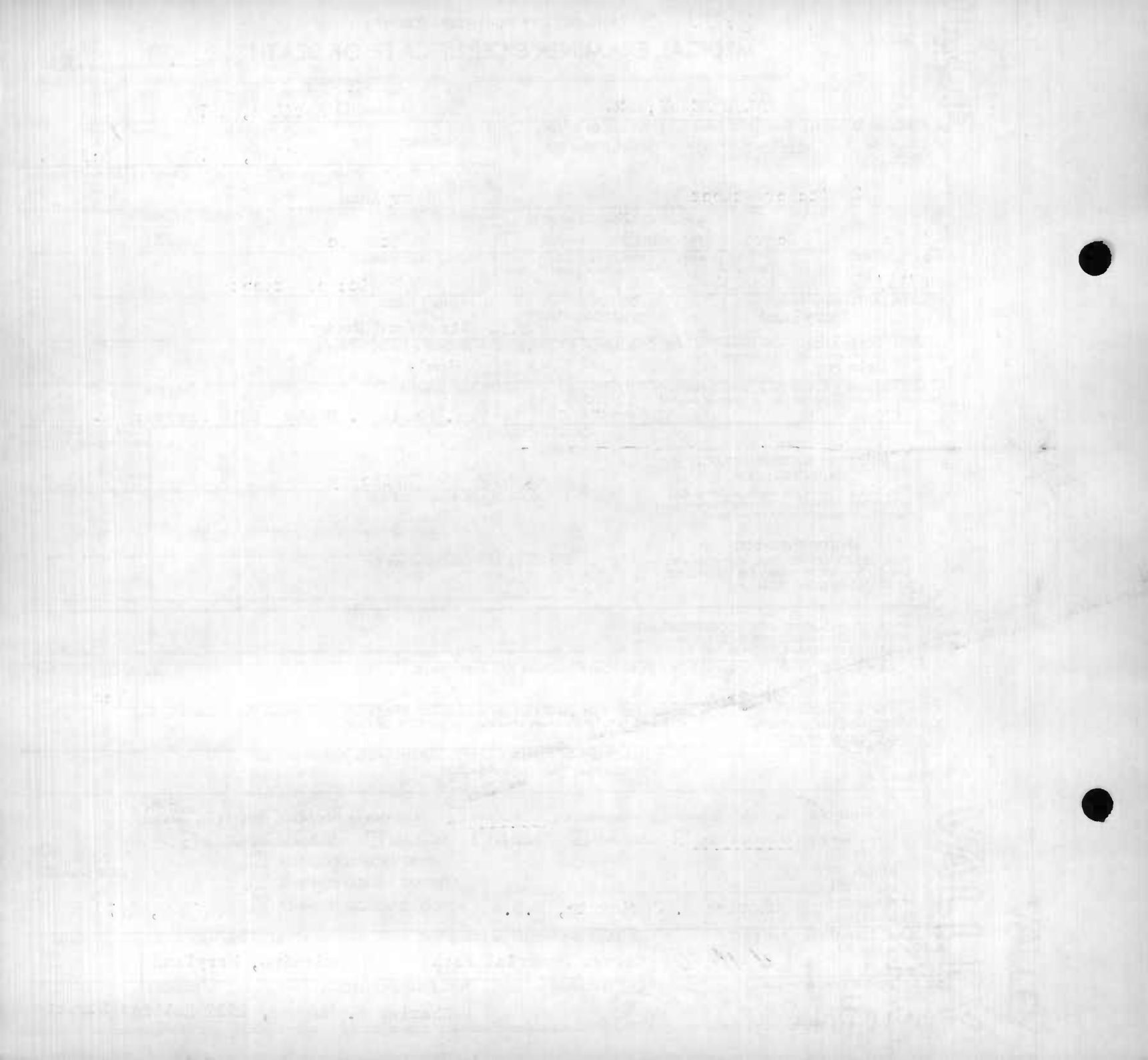
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
S-51670 3798				70 3798	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <u>Lucy J. Sanford</u>				2. DATE AND HOUR OF DEATH <u>4/2/70</u> <u>930</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>805</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Mt Sinai Nursing Home</u> <u>4613 Park Heights Ave</u> <u>Balto Md</u>				C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2022 N. Washington St</u>					
5. SEX <u>Female</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-1887</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			11. BIRTHPLACE (State or foreign country) <u>Person Co., N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Betlee Lawson</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Ramsey</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>945-10-4675</u>		
17. INFORMANT <u>Mrs. Clara Lancaster</u>			ADDRESS <u>2022 N. Washington St.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>4123</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Cerebrovascular Acc</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>H/OVD</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> 19 <u>70</u> to <u>4/2</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour end from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edward B. Hallins MD</u>				23B. DATE SIGNED <u>4/6/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>EDWARDS, KALLINS MD</u>				23D. ADDRESS <u>6000 Park Hts Ave Baltimore Md 21215</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-6-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Ruth D. Collick</u>	
				ADDRESS <u>2431 E. Oliver St.</u>	



N-100 70 3799 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 3799

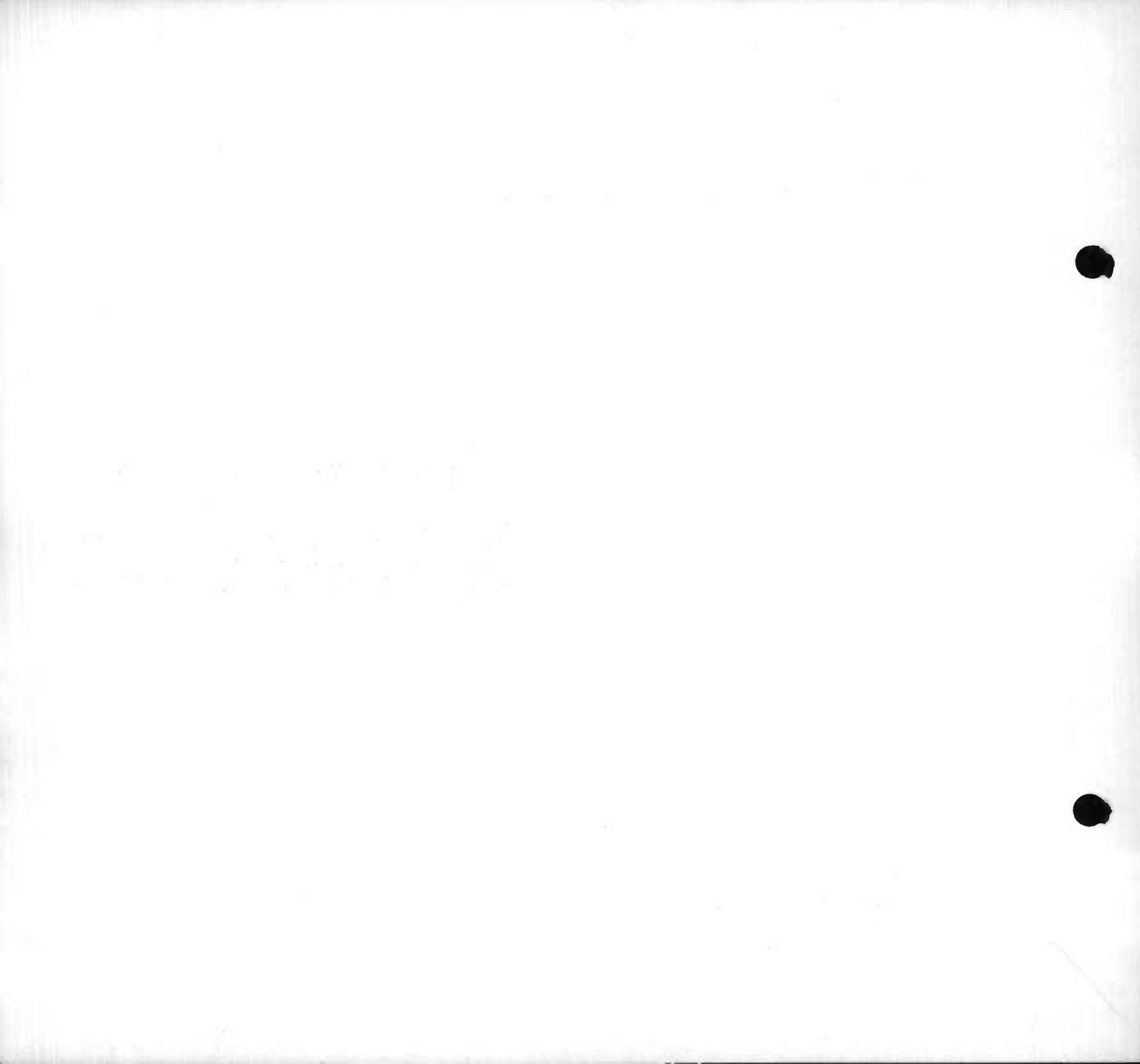
BIRTH NO.		1. NAME OF DECEASED (Type or Print) RALPH NEWBY, SR.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> April 8, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 602 Pitcher Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 8, 1970 6:50 P. M.		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE Maryland B. COUNTY 1402	
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 6/15/35		10. AGE (In years last birthday) 34		E. STREET AND NUMBER 602 Pitcher Street	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Stratford Newby	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Homly	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-28-6789		18. INFORMANT ADDRESS Mrs. Marie E. Newby 1510 Presser Ct. 21217	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 345.9 I Epilepsy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 9, 1970 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-11-70		24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park	
24D. LOCATION (City, town, or county) (State) Muirkirk, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 10 1970 25B. NAME OF REGISTRAR Charles E. Hughes 25C. FUNERAL DIRECTOR ADDRESS Charles E. Hughes, 1532 Hollins Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

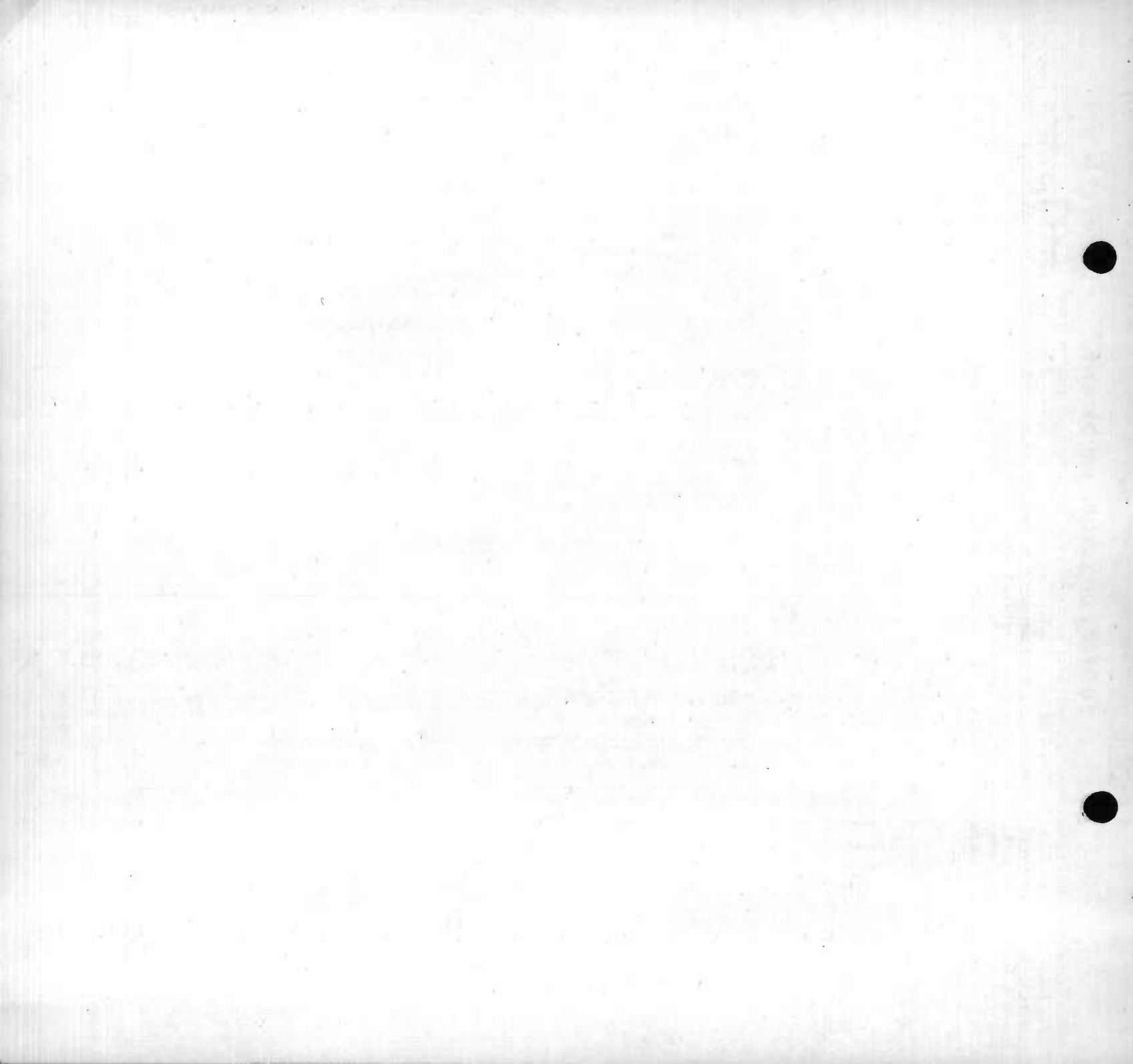
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 3800
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Elen Robinson</i>		2. DATE AND HOUR OF DEATH <i>4/19/70 11:00 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		13-03	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland University of General Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>2518 Madison Avenue</i>					
5. SEX <i>F</i>	6. RACE <i>N N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>?</i>	9. AGE (In years lost birthday) <i>83</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Dlex Wood</i>			
14. MOTHER'S MAIDEN NAME <i>Mary</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <i>412.41</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Atherosclerosis Cardio- and Cerebrovascular Disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebrovascular Disease</i>			
		(B) <i>Atherosclerosis Cerebrovascular</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebrovascular Disease</i>			
		(C) <i>Myocardial Infarction</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2/70</i> 19 <i>70</i> to <i>4/9</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>4/9</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Carol Lee Roski MD</i>				23B. DATE SIGNED <i>4/19/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Carol Lee Roski MD</i>				23D. ADDRESS <i>Maryland General</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/14/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>	
24D. LOCATION <i>Baltimore Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 10 1970</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>			
25D. ADDRESS <i>1206 W North Ave</i>					

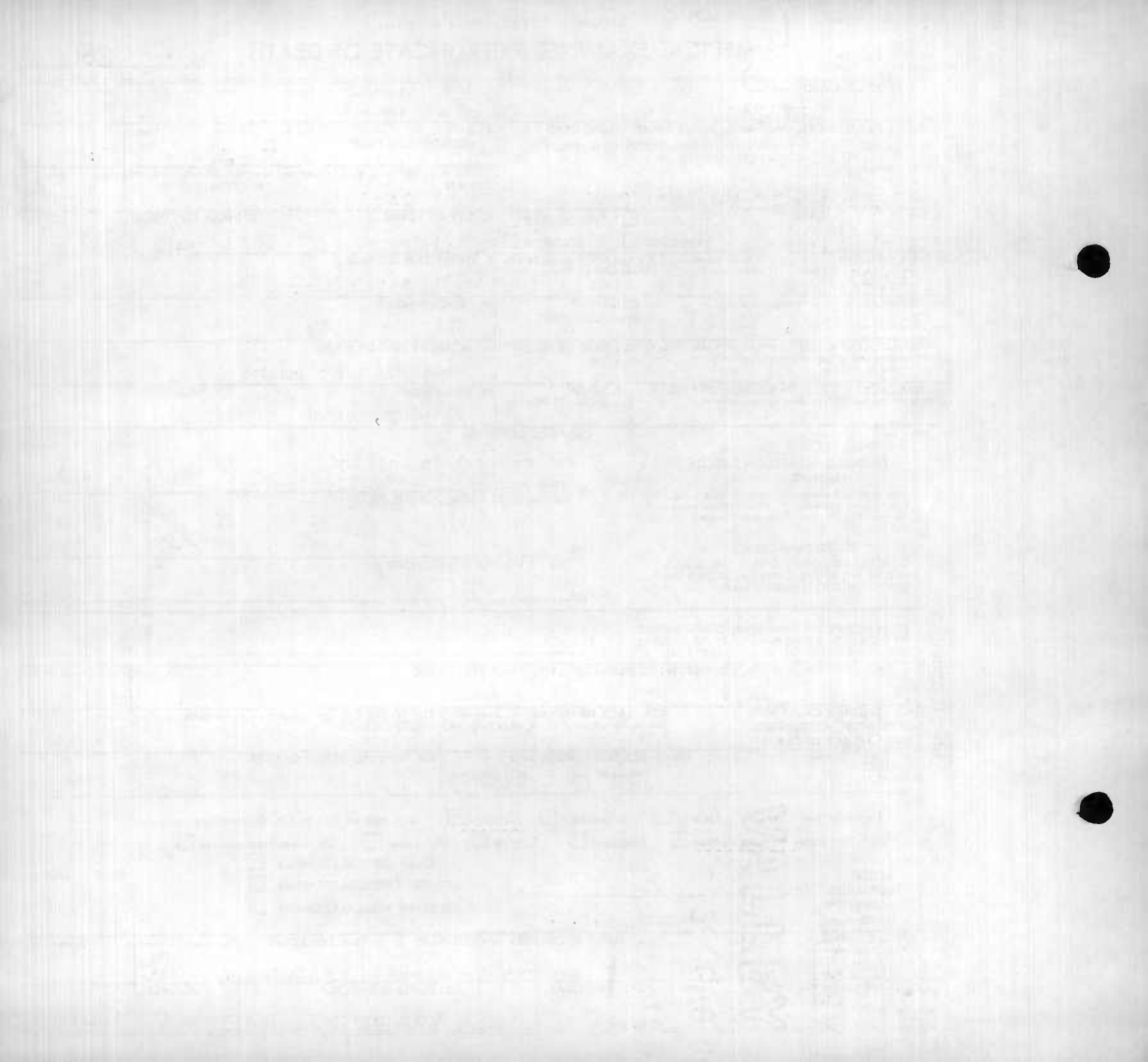


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3801				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3801	
1. NAME OF DECEASED (Type or Print) ALICE BROWN				2. DATE AND HOUR OF DEATH 4/7/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1024 Stoddard Court				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1024 Stoddard Court			
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> XXXX DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Carrie Bibbs			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-30-6370		17. INFORMANT Mrs Basnight, 1615 Bakebury Court			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Desnutrition				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 to 3-27-1970, that (I) (we) last saw the deceased alive on March-27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Dr. Gonzales				23B. DATE SIGNED 4-9-70			
23C. PHYSICIAN'S NAME (Type) ANGEL S. GONZALEZ				23D. ADDRESS 301 McMechen St - Balto - Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/70		24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore M.	
25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave			





1081097 AS
TELE. SARA M
4 25 37

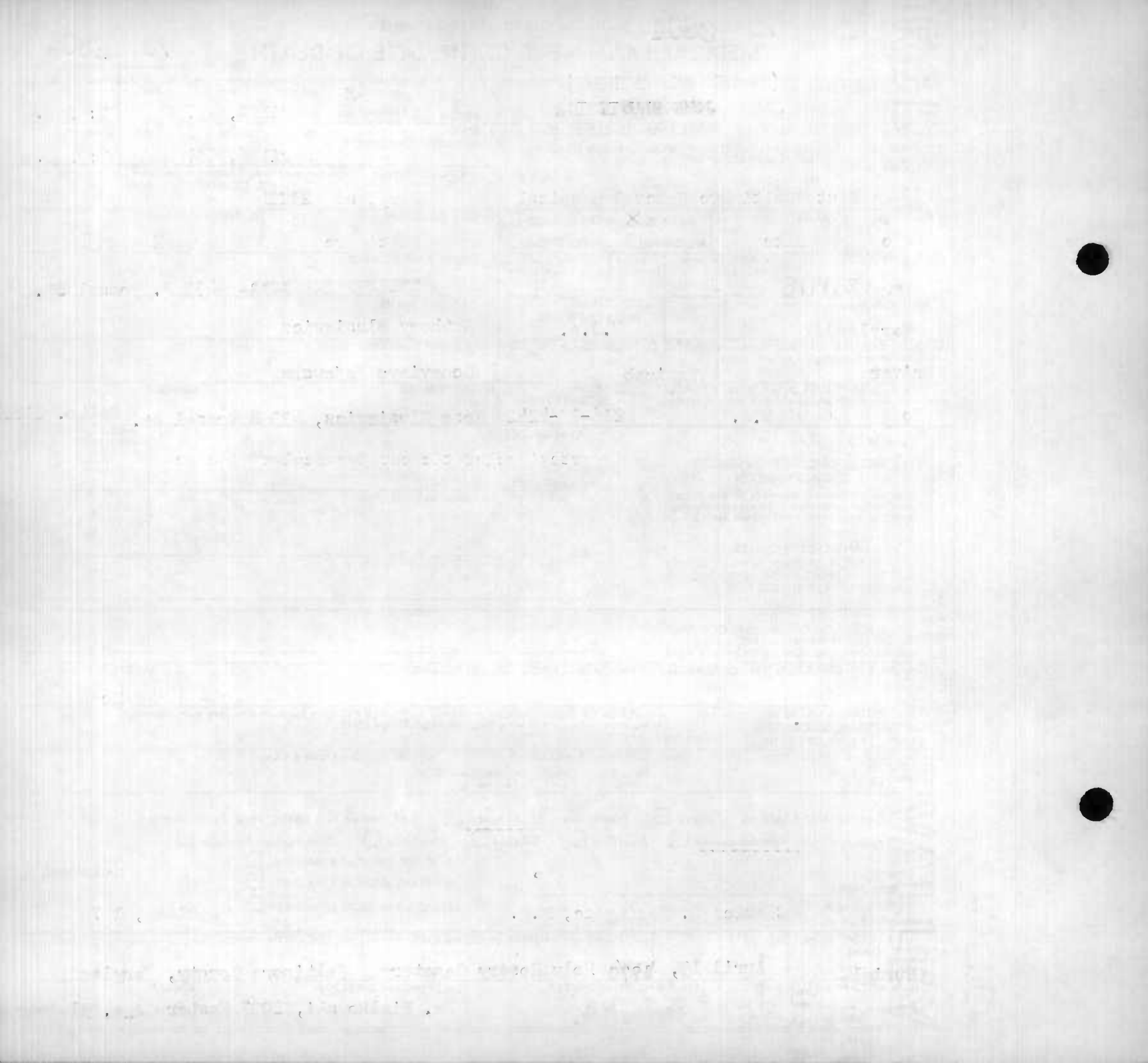
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3803	
BIRTH NO. 70 3803		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SARA TEAGLE			2. DATE AND HOUR OF DEATH 4-8-70 2:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL 33			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 843 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1215 N. POTOMAC ST.		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-37	9. AGE (In years last birthday) 33	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Classified Clerk		10B. KIND OF BUSINESS OR INDUSTRY Social Security		11. BIRTHPLACE (State or foreign country) South Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MATTHEW MOODY			14. MOTHER'S MAIDEN NAME NEDIE BURNS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Charles H. Teagle 1215 N. Potomac St.		
18. 282.51 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHRONIC RENAL DISEASE 7 YEARS DUE TO, OR AS A CONSEQUENCE OF: UREMIA SECONDARY TO R. RENAL VEIN THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) SICKLE CELL TRAIT (C) HYPERTENSION, CONGESTIVE HEART FAILURE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (A.P.P.R.O.X.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 4/8/70, that (I) (we) last saw the deceased alive on 4/8/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jaime F. Casellas M.D. DEGREE				23B. DATE SIGNED 4-8-70	
23C. PHYSICIAN'S NAME (Type) JAIME F. CASELLAS DEGREE		23D. ADDRESS JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/11/70		24C. NAME OF CEMETERY or CREMATORY Laurel Mem. Park, Laurel, Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. APR 10 1970			
25B. NAME OF REGISTRAR W. E. Taylor M.D.		25C. FUNERAL DIRECTOR Address 1297 N. Calhoun St.			

A535 1

BALTIMORE CITY HEALTH DEPARTMENT				70 3804	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 3804	
BIRTH NO. (STANISLAUS ANTHONY)					
1. NAME OF DECEASED (Type or Print)		JAMES JOHN BLUSIEWICZ		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour April 8, 1970 2:05 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 8, 1970 2:05 P.M.		5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE B. COUNTY Maryland 21224 2605	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH MAR 18, 1918		10. AGE (In years last birthday) 52	11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Anthony Blusiewicz			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		14B. KIND OF BUSINESS OR INDUSTRY Taxicab		15. MOTHER'S MAIDEN NAME Genevieve Majewska	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No N.A.		17. SOCIAL SECURITY NO. 216-10-4242		18. INFORMANT Rose Blusiewicz, 433 S Bonsal St. Balto. 21224	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: April 9, 1970					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 13, 1970		24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 18 1970		24F. NAME OF REGISTRAR 2605 E. Fialkowski	
24G. FUNERAL DIRECTOR Wm. Fialkowski, 2007 Eastern Ave. 31 Zone					



B-630

70 3805

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3805

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALBERT BYRD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 7, 1970 7:57 A.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2-16-33		10. AGE (In years last birthday) 46	
11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Stella Crea	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes 4/26/45 - 8/21/46		17. SOCIAL SECURITY NO. 577-24-7233	
18. INFORMANT ANNA Holmes - SAME		ADDRESS	
19. E 910.19 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Epilepsy		CAUSE OF DEATH Drowning (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-7-70 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Bathtub - 2015 W. North Avenue		22F. HOW DID INJURY OCCUR? Subject drowned in bathtub	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-10-70	
24C. NAME OF CEMETERY or CREMATORY Louisa Pk. Nat'l.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		25B. NAME OF REGISTRAR E. Taylor	
25C. FUNERAL DIRECTOR Kelson F.A.		ADDRESS 1348 Calhoun St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-614 70 3806		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3806	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALFRED C. VERVALEN		2. DATE AND HOUR OF DEATH 04-09-70 12:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY U.S.A. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5005 ST. ALBANS WAY			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-09-01	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN PROPRIETOR PRESIDENT - REAL ESTATE		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) NEW YORK	
13. FATHER'S NAME SAMUEL A. VERVALEN		14. MOTHER'S MAIDEN NAME CARRIE CARSON		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN NO		16. SOCIAL SECURITY NO.		17. INFORMANT (HIMSELF) MRS. ALFRED C. VERVALEN (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 250.9 I I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Diabetes - ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH From Negative Septicemia? (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetes - (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 03-18 19 70 to 04-09 19 70 that (I) (we) last saw the deceased alive on 04-09 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Yasumasa Yamasaki M.D.				23B. DATE SIGNED 04-09-70	
23C. PHYSICIAN'S NAME (Type) YASUMASA YAMASAKI		23D. ADDRESS M.D. 33RD AND CALVERT STS. BALTO. M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 4-13-70		24C. NAME of CEMETERY or CREMATORY Lorraine Pk. Mausoleum	
24D. LOCATION Baltimore Co. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 10 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore, Md. 21212			

THE NEW YORK HOSPITAL
2502 27 ALBANY WAY

MALE WHITE
11-01-01 88

SAMUEL A. VERVALEN
NEW YORK
CARRIE CARSON
HIMSELF

04-09 03-18 04-04

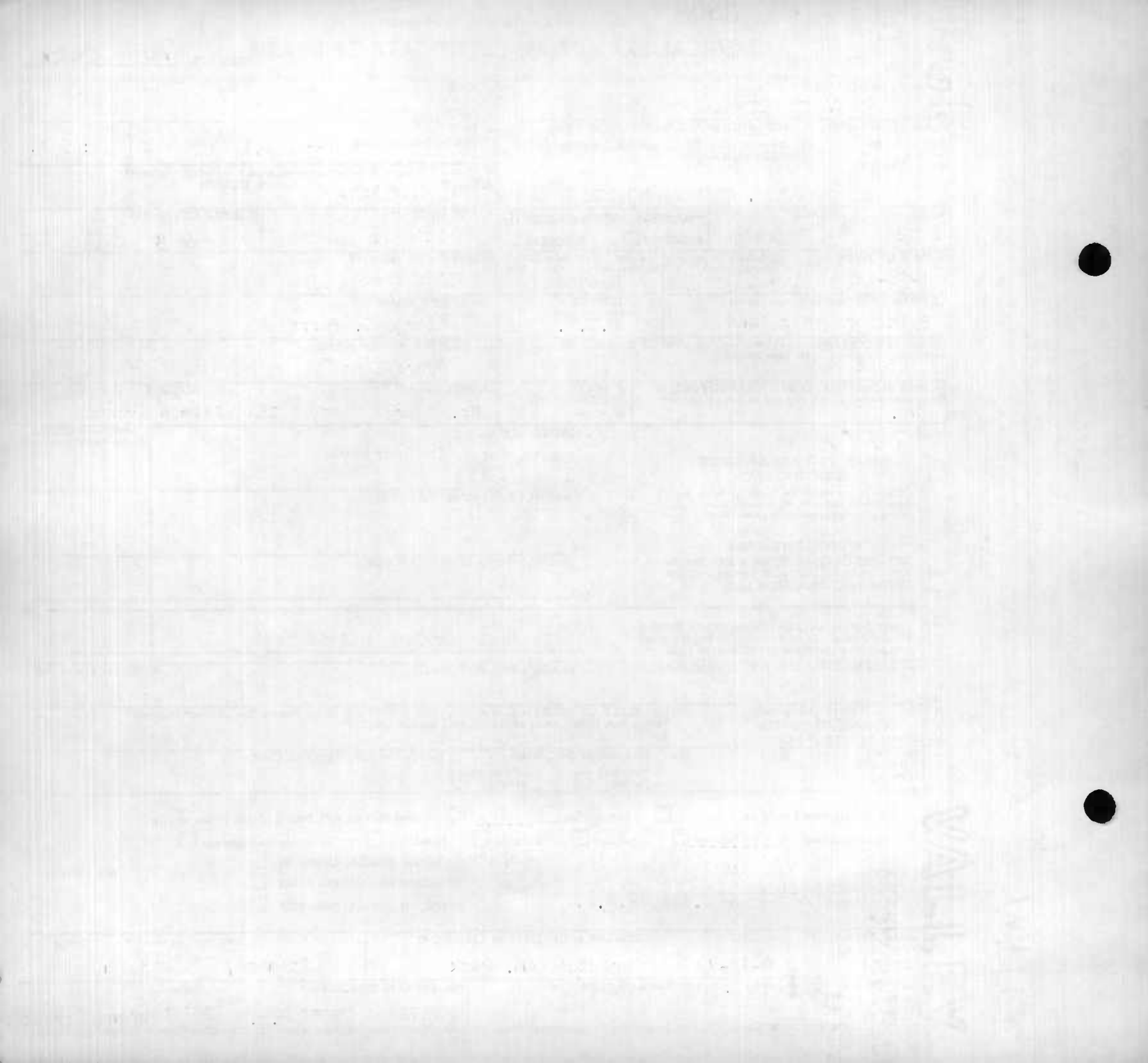
YASUAKI YAMAZAKI
MD 33RD AND CALVERT ST BALTIMORE
04-04 04-04

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. [REDACTED]	
BIRTH NO. 70 3807		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) (Abbott) Bennett, Albert		2. DATE AND HOUR OF DEATH 4/7/70 7 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2716			
FULL NAME OF HOSPITAL OR INSTITUTION Dukeland Nursing Home 90 1501 N. Dukeland Street		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4721 Delaware Avenue					
5. SEX male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/194	9. AGE (In years last birthday) 75 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME UNK		14. MOTHER'S MAIDEN NAME UNK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. 249-28-1639-A		17. INFORMANT ENLA Mrs Ann Reed	
ADDRESS 4721 Delaware Ave					
18. 440.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Liver failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-2- 19 70 to 4-7- 19 70 , that (I) (we) last saw the deceased alive on 4-7- 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lercival C. Smith		DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4-8-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-11-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE RECEIVED BY HEALTH DEPT. APR 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR 1704 Laurens St.	

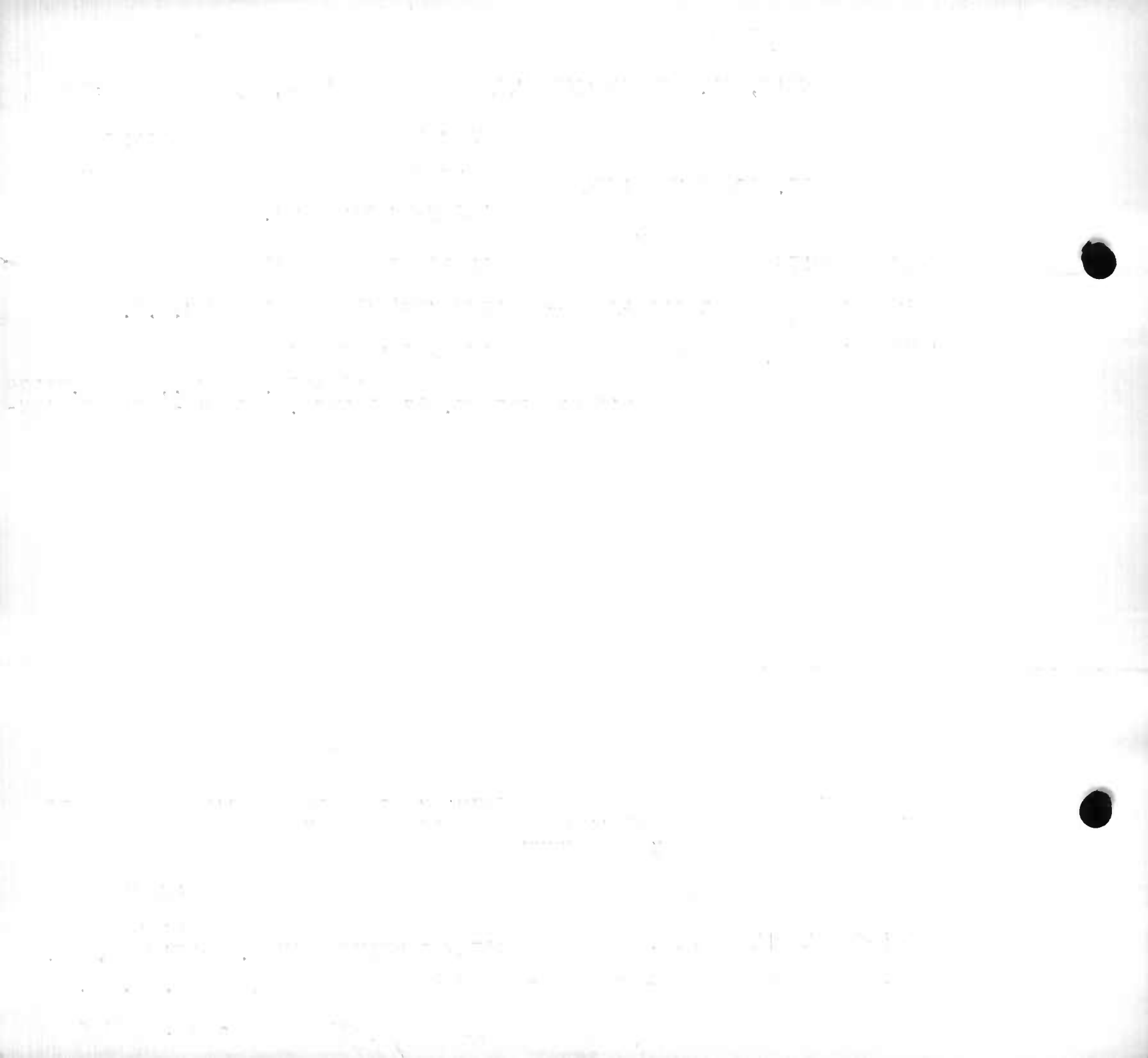
1. NAME OF DECEASED (Type or Print) DAVID PERRY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTO. GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year April 7, 1970 6:45 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2542	
9. DATE OF BIRTH 1-18-1970		10. AGE (In years last birthday) 3 Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George E. Perry		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	
15. MOTHER'S MAIDEN NAME Debra Epps		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO. -0-		18. INFORMANT Mr. George Perry	
19. 795 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Bilateral purulent otitis media		CAUSE OF DEATH Sudden death in infancy (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/7/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-10-70	
24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		25B. NAME OF REGISTRAR Charles E. Jackson, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>B-600</u> <u>70 3809</u>				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 3809</u>			
1. NAME OF DECEASED (Type or Print) <u>BAIR, SR. HOMER E. MANUEL</u>				2. DATE AND HOUR OF DEATH <u>APRIL 8, 1970</u> <u>1:30A</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>ANNE ARUNDEL</u> <u>21225 5200</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>406 HOLY CROSS RD.</u> <u>21225</u>							
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 30 05</u>		9. AGE (In years last birthday) <u>64</u>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OPERATOR</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD (Penn Central)</u>				11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			
13. FATHER'S NAME <u>JOHN BAIR (John Edward Bair)</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA (WILLIAMS)</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217 01 9377</u>				17. INFORMANT <u>ENS AVES. BALTO. ADDRESS MD. 21229</u> <u>ST. AGNES HOSP. RECORDS-CATON & WILK-</u>			
18. <u>5679 + 1990</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>generalized arteriosclerosis</u>				CAUSE OF DEATH <u>bilateral bronchopneumonia + pulmonary abscesses</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>pusulent peritonsillitis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>FEBRUARY 23</u> 19 <u>70</u> to <u>APRIL 8</u> 19 <u>70</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>APRIL 8</u> 19 <u>70</u> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <u>(XXXX)</u> view the body after death.											
23A. SIGNATURE <u>Jaime V. del Pilar</u>								23B. DATE SIGNED <u>4/8/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>JAIME DEL PILAR, M.D.</u>								23D. ADDRESS <u>CATON & WILKENS AVES. BALTIMORE, MD. 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4/11/70</u>				24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>			
24D. LOCATION (City, town, or county) (State) <u>Taylor Ave. Balto. Co. Md.</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			
25C. FUNERAL DIRECTOR <u>McCully F. H.</u>				25D. ADDRESS <u>237 Patepsco Ave. 21225</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

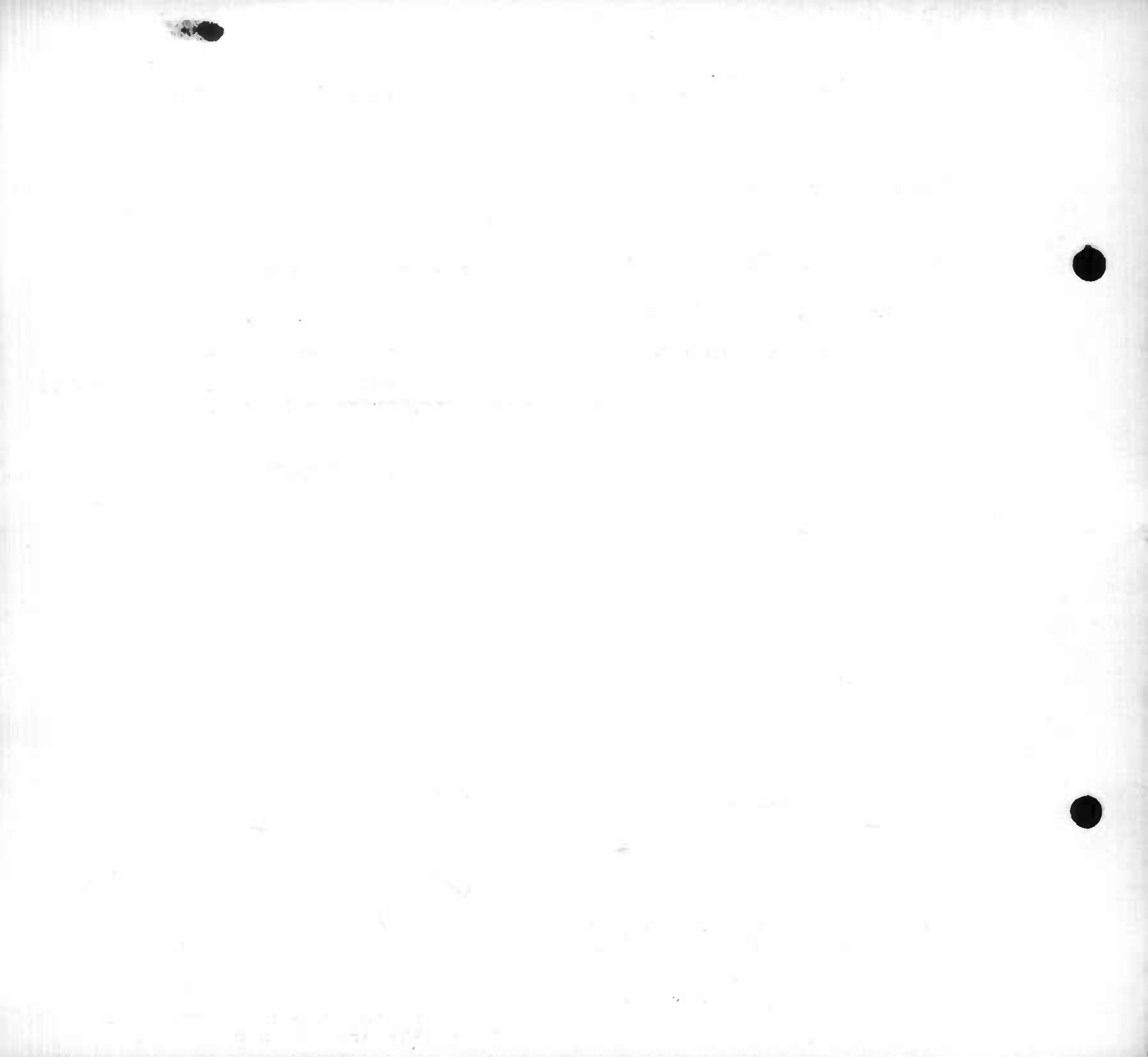
G-560		70 3810		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 3810	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) GAYNOR, Irving				2. DATE AND HOUR OF DEATH 4-8-70 3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY ANCO.				5. CITY OR TOWN Glen Burnie D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				E. STREET AND NUMBER 7499B Furnace Branch Road					
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-7-17	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Goldberg				14. MOTHER'S MAIDEN NAME Rose Gordon					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6-25-42 to 2-10-44				16. SOCIAL SECURITY NO. 115-12-60-53		17. INFORMANT VA Hospital Records ADDRESS Baltimore, Maryland 21218			
18. 530.31 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bilateral Pneumonia with Emphyemas				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Esophageal Anastomatic Leak				11 Days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Post Op Left Colon Interposition and Distal Esophagectomy				(B) DUE TO, OR AS A CONSEQUENCE OF: Upper GI Hemorrhage				7 Days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II				(C) DUE TO, OR AS A CONSEQUENCE OF: Upper GI Hemorrhage				13 Days	
19A. DATE OF OPERATION 3-27-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Benign Esophageal Structure		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 4, 1970 to April 8, 1970 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 8, 1970 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.									
23A. SIGNATURE Carl E. Bredenberg				23B. DATE SIGNED 4-8-70					
23C. PHYSICIAN'S NAME (Type) CARL E. BREDEBERG MD				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE April 10, 1970		24C. NAME OF CEMETERY OR CREMATORY Beth Moses Pine Lawn		24D. LOCATION (City, town, or county) (State) New York N.Y.			
25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Sylvan Lewis & Son		ADDRESS 9610 Reisterstown Rd.			



FUNERAL DIRECTOR: IMPORTANT

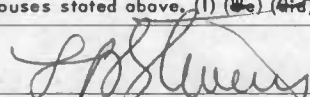
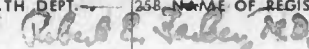
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200 70 3811		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED] 70 3811	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Naomi Beck</i>		2. DATE AND HOUR OF DEATH <i>4-4-70 11:20 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Baltimore Md</i> B. COUNTY <i>2047</i>		C. CITY OR TOWN <i>2047</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View Ncc</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>70</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine Opr.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Pittsburgh Platt Glass</i>		8. DATE OF BIRTH <i>5-16-91</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		9. AGE (In years last birthday) <i>78</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Daniel Elmer Smith</i>		14. MOTHER'S MAIDEN NAME <i>Alice Marie Scott</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>212-20-9732</i>		17. INFORMANT <i>1629 Searles Rd. Mrs. Grace Trainor, cousin</i>		ADDRESS <i>21222</i>	
18. <i>412.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Decomp</i> <i>A.S.C.U.D.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Few Minutes</i>	
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Genile Arterioscl</i>		(C) <i>Paranoid Schizophrenia</i>		?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>II</i>					
19A. DATE OF OPERATION <i>None</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Net While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 3</i> 19 <i>70</i> to <i>4/4</i> 19 <i>70</i> that (I) (was) last saw the deceased alive on <i>2/23</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) <i>(did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>Kenneth Krulvitz M.D.</i>		23B. DATE SIGNED <i>4/7/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Kenneth Krulvitz, M.D.</i>	
23D. ADDRESS <i>7538 Holabird Avenue</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/8/70</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i>		24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		24E. STATE <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 10 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>	
25D. ADDRESS <i>3331 Brehms Lane</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3812
<div style="font-size: 2em; font-weight: bold;">O-165</div> <div style="font-size: 3em; font-weight: bold;">70 3812</div>		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		
		ANTOINETTE (TONY) OBERENDER		
2. DATE AND HOUR OF DEATH		April 6, 1970 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <div style="font-size: 2em; font-weight: bold;">44</div> <div style="font-size: 2em; font-weight: bold;">99</div> Union Memorial Hospital (DOA)		A. STATE Md., 21213		
		B. COUNTY Baltimore		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER 3213 Clifftmont Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3/17/86	84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife		at home		Germany
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
John L. Behme		unknown		U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
		219-30-3448A		Mrs. Dorothy Arvin, dght. above
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE <i>Coronary Thrombosis due to Advanced Arteriosclerosis</i>		
		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>3/4 1959</u> to <u>4/6 1970</u> , that (I) (we) last saw the deceased alive on <u>June 30 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
 Dr. L. B. Stevens		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 4/7/70		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Dr. L. B. Stevens		3400 Erdman Avenue		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY
Burial		4/9/70		Parkwood Cemetery
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR ADDRESS		
Baltimore, Md.		Schimunek Funeral Home, Inc. 3331 Brehms Lane		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		
APR 10 1970		 VS 150-REV. 1/1/68		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3813
S-624		70 3813	CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>SHIRCHIFF LOYAL Jackson</u>		2. DATE AND HOUR OF DEATH <u>4-6-70</u> <u>11 35</u> A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> & COUNTY <u>2643</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL INC.</u> <u>37</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		E. STREET AND NUMBER <u>4008 ELMORA AVENUE</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-19-99</u>		9. AGE (In years last birthday) <u>70</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Tool Room</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Armco Steel</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>LAURENCE Shirchiff</u>		
14. MOTHER'S MAIDEN NAME <u>? Mary Reel</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u> <u>no</u>		
16. SOCIAL SECURITY NO. <u>196-07-7682</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>		
18. <u>19831</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Possible Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Possible metastatic CA to brain +</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Lungs, primary site undetermined</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Mar 1</u> 19 <u>70</u> to <u>April 6</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>April 6</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>A. T. Hipolito, M.D.</u>		23B. DATE SIGNED <u>4/6/70</u>		23C. PHYSICIAN'S NAME (Type) <u>A. T. HIPOLITO, M.D.</u>
23D. ADDRESS <u>MERCY Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>4/9/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

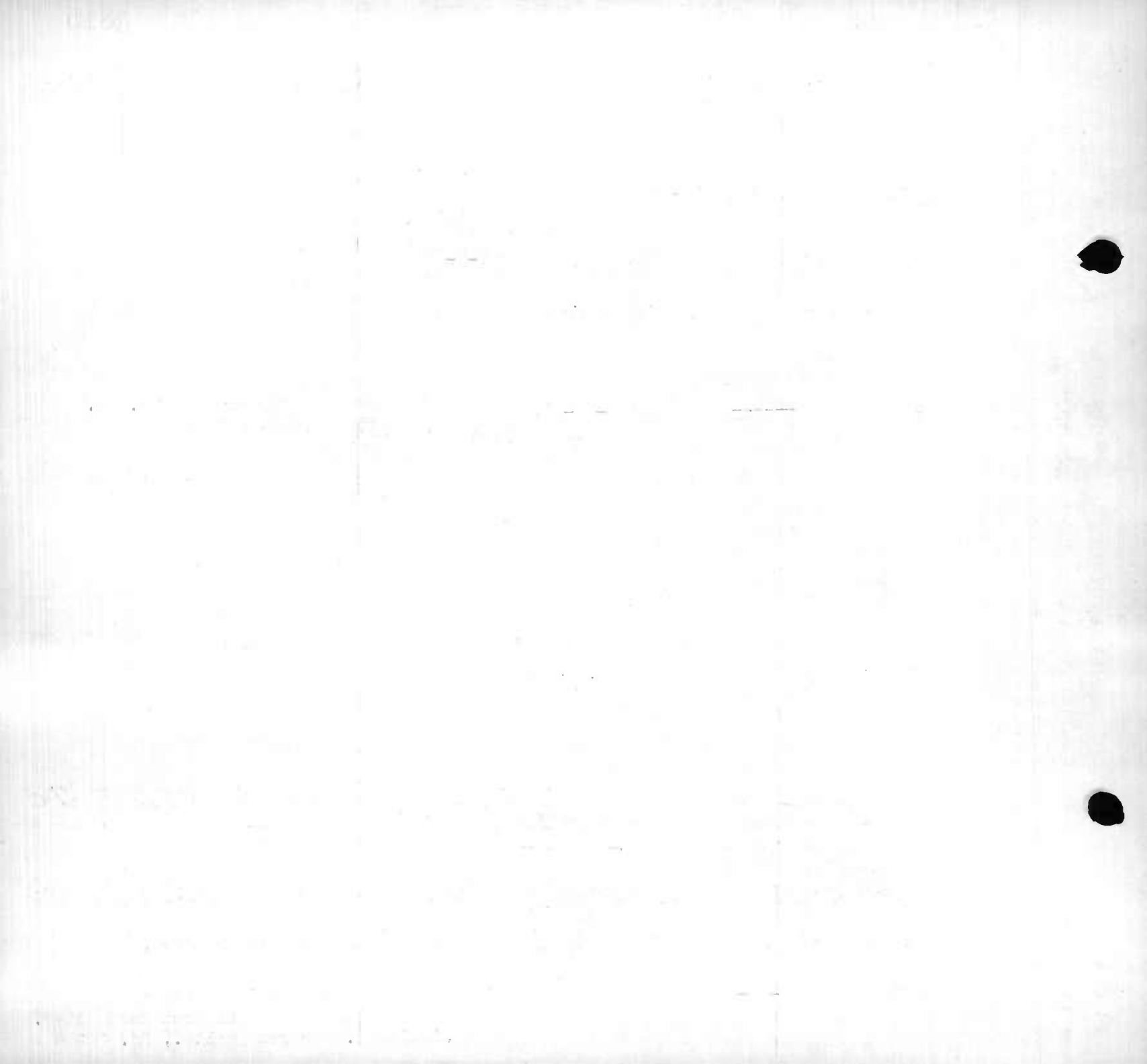
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3814</u>	
BIRTH NO. <u>H-325 70 3814</u>		1. NAME OF DECEASED (Type or Print) <u>HUDSON, Coleman MNM</u>		2. DATE AND HOUR OF DEATH <u>4-5-70</u> <u>4:10</u> P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>23 Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>907</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1568 Coswell Street</u>		
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-18</u>	9. AGE (in years last birthday) <u>51</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Industrial Chem</u>		11. BIRTHPLACE (State or foreign country) <u>Lexington, Ky.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Louis Hudson</u>		
14. MOTHER'S MAIDEN NAME <u>Lucinda Kidd</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 8-12-40 to 6-18-45</u>		
16. SOCIAL SECURITY NO. <u>404-34-71-62</u>			17. INFORMANT <u>VA Hospital Records</u> <u>Baltimore, Maryland 21218</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>162.1 I METASTATIC CARCINOMA OF LUNG LEFT UPPER LOBE.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months, plus</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>BRONCHOPNEUMONIA</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>10</u> (this hospital) attended the deceased from <u>March 30,</u> 19 <u>70</u> to <u>April 5,</u> 19 <u>70</u> that <u>11</u> (we) last saw the deceased alive on <u>April 5,</u> 19 <u>70</u> and that in <u>11</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>11</u> (We) (did) <u>not</u> view the body after death.					
23A. SIGNATURE <u>Carl E. Bredenberg M.D.</u>			23B. DATE SIGNED <u>4-6-70</u>		23C. PHYSICIAN'S NAME (Type) <u>CARL E. BREDEBERG, M.D.</u>
23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>			23E. DATE REC'D BY HEALTH DEPT. <u>APR 10 1970</u>		
23F. NAME OF REGISTRAR <u>John E. Sasser, Jr.</u>			23G. FUNERAL DIRECTOR <u>Schimunek Funeral Home, Inc.</u> <u>3331 Brehms Lane</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/9/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto. Nat. Cem.</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		24E. STATE (State) <u>Md.</u>			

1568 Carswell St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3815	
<div style="font-size: 2em; font-weight: bold;">G-640 70 3815</div>				<div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>	
1. NAME OF DECEASED (Type or Print) Thomas Grill				2. DATE AND HOUR OF DEATH <div style="font-size: 1.5em;">APRIL 8, 1970 9:20 A. M.</div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.5em;">90 Ardleigh Home & Infirmary</div>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland XXXXXXXX XX B. COUNTY 2005 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2639 Dulaney Street	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-85		9. AGE (In years lost birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-09-7161A		
17. INFORMANT Records			ADDRESS Ardleigh Home & Infirmary Balto. Md.		
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <div style="font-size: 1.5em; text-align: center;">CAUSE OF DEATH HYPERTENSION CARDIO- VASCULAR DISEASE</div> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.5em;">10 YRS</div>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <div style="font-size: 1.5em; text-align: center;">AMPUTATION RT LEF</div>					
19A. DATE OF OPERATION JUNE 1969		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED tumor of heart		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 19 69 to APRIL 8, 1970 , that (I) (we) last saw the deceased alive on APRIL 7 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd E. Saylor, M.D.				23B. DATE SIGNED April 9, 1970	
23C. PHYSICIAN'S NAME (Type) LLOYD E. SAYLOR M.D.		23D. ADDRESS 3902 Greenmount Ave.,			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-10-70		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Park	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland		25A. DATE RECEIVED BY HEALTH DEPT. APR 10 1970			
25B. NAME OF REGISTRAR Walter E. Saylor, M.D.		25C. FUNERAL DIRECTOR William E. Johnson			
25D. ADDRESS 8521 Loch Raven Blvd.		25E. CITY, TOWN, OR COUNTY (State) Balto., Md. 21204			



1

E-152

70 3816

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3816

BIRTH NO.

1. NAME OF DECEASED (Type or Print) J. LEWIS EVANS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 8, 1970 Hour 4:20 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year April 8, 1970 Hour 4:20 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN ELK RIDGE	
9. DATE OF BIRTH April 19, 1933		10. AGE (in years lost birthday) 36	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Broyles Funeral Home, Union, West Virginia		ADDRESS West Virginia	
19. E 815.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebro-cranial injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Hanover Road - Howard County		22F. HOW DID INJURY OCCUR? Driver in auto-fixed object collision	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 3 30 70 9:40 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 9, 1970 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-12-1970	
24C. NAME OF CEMETERY or CREMATORY Lebanon Cemetery		24D. LOCATION (City, town, or county) (State) Union, West Virginia	
25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		25B. NAME OF REGISTRAR Robert E. Seiberg, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue		ADDRESS 21229	

Letter from M.E.'s office

4-22-70

M.H.

FUNERAL DIRECTOR: IMPORTANT

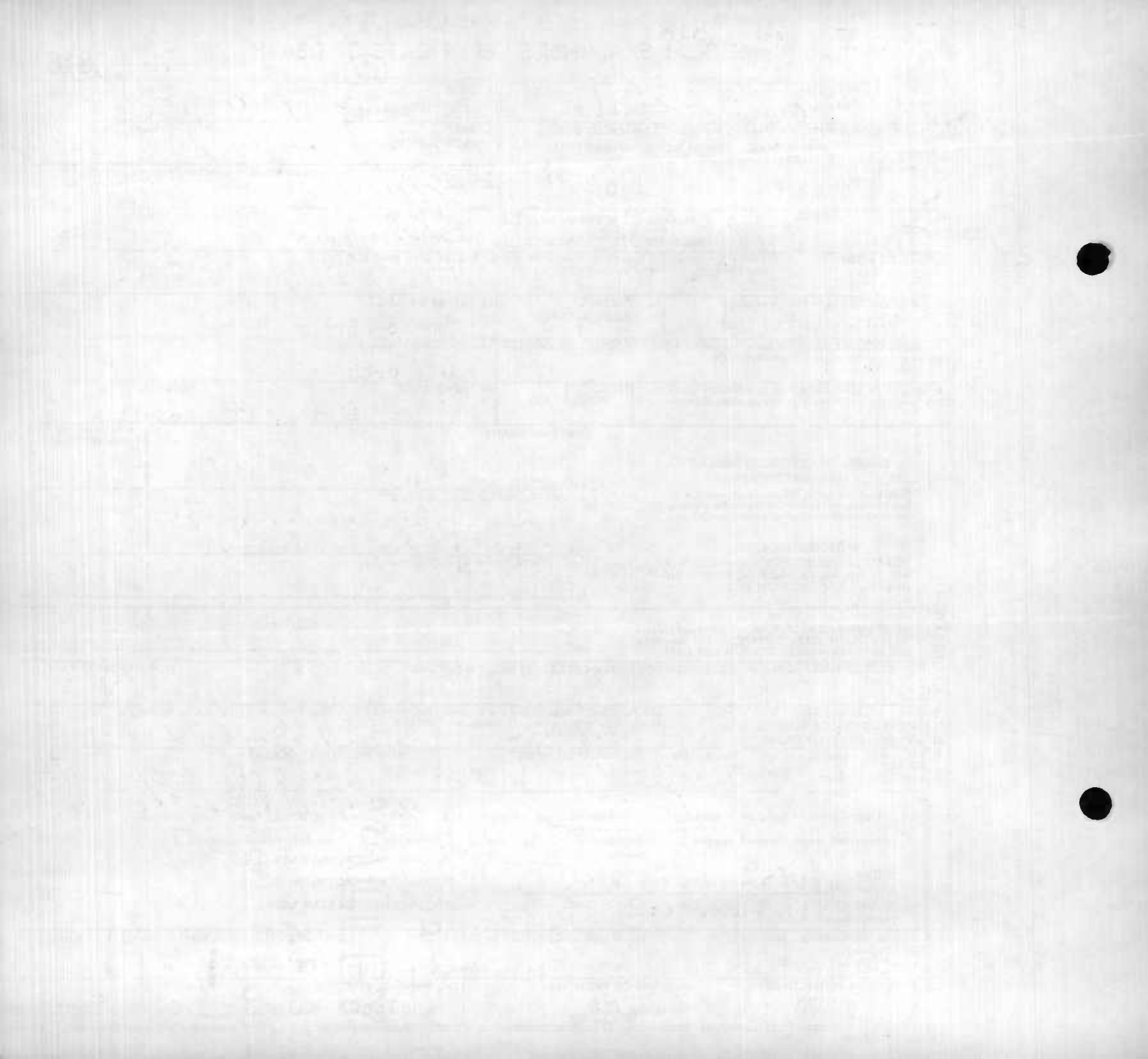
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
W-452 70 3817					REG. NO. 70 3817				
BIRTH NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
MARTHA W. WILLIAMS					April 7, 1970				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION					A. STATE B. COUNTY				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					Maryland Baltimore 5300				
40 St. Agnes Hospital Wilkins & Caton Aves.					C. CITY OR TOWN D. INSIDE CITY LIMITS?				
					Arbutus YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER					4809 Westland Blvd. Apt. -B				
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12-22-1907		62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired Secretary				Maryland		U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Julius A. Wilkins					Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					214-01-8154		Mrs. Matilda W. Gantt, 1122 Courtney Rd. 21227		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				NO					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work							
22. I certify that (I) (this hospital) attended the deceased from 3/26 1968 to 4/7 1970, that (I) (we) last saw the deceased alive on 4/7 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Dr. James N. Frederick					4/9/70				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Dr. James N. Frederick					1311 Francis Avenue, Baltimore, Maryland				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		4-10-70		Baltimore National Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 10 1970		Robert E. Taylor, M.D.		Howard H. Hubbard		4107 Wilkins Ave. 21229			

211

820

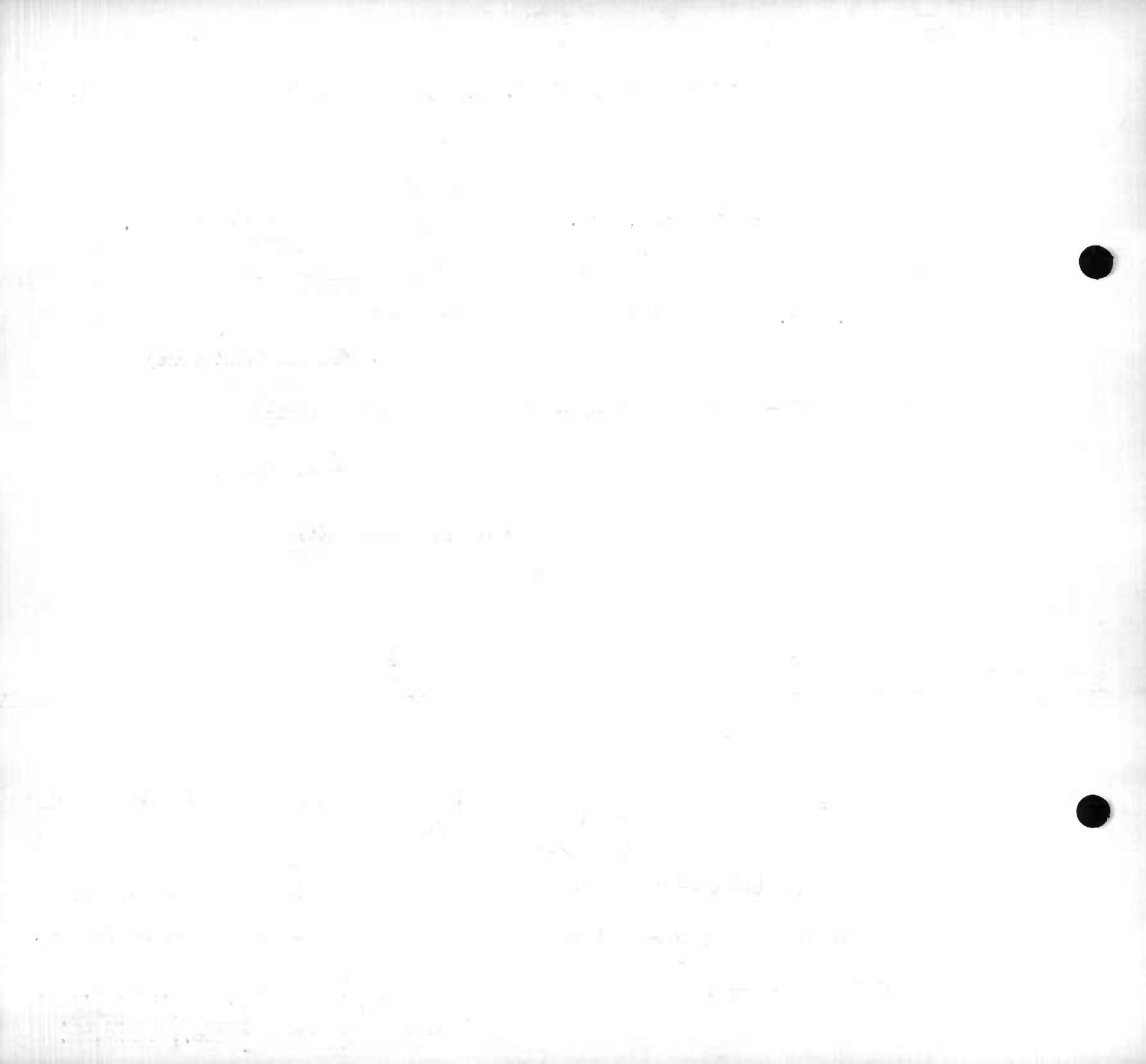
F-435		70 3818		BALTIMORE CITY HEALTH DEPARTMENT	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 70 3818	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Blanche Feldon</i>			2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 4 4 70 430 P.M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>39 Provident Hosp.</i>			3. DATE PRONOUNCED DEAD Month Day Year Hour 4 4 70 430 P.M.		
5. USUAL RESIDENCE (Where deceased lived, if Institution residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1401</i>					
6. SEX <i>Fem</i>	7. RACE <i>Col</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <i>2/9/19</i>		10. AGE (in years lost birthday) <i>50</i>	11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Thomas Ivery</i>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		15. MOTHER'S MAIDEN NAME <i>Elizabeth</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT <i>MRs Ida Wilkins, 1700 McCulloh St.</i>	
19. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <i>Smoke & Soot</i> <i>Inhalation incident to conflagration.</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) <i>conflagration.</i> (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <i>NO</i>	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>1707 Linden Ave 1401</i>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <i>4 4 70 430 P</i>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <i>House fire apparently during alcoholic intoxication</i>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. DEPUTY CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <i>Werner U. Spitz</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>4.5.70</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/9/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT Auburn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>APR 10 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Adolphus Halstead</i>	
				ADDRESS <i>1206 W North Av</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3819	
E-540 70 3819 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Ralph Emmel (RALPH C. EMMEL)		4/8/70 5:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
37 Mercy Hospital, Inc.			Maryland 2605		
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
Male White			Baltimore YES <input type="checkbox"/> NO <input type="checkbox"/>		
8. DATE OF BIRTH 9. AGE (In years last birthday) 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY			E. STREET AND NUMBER		
1/12/39 31 Asst. Mgr. Hotel			303 Folcroft Street # 21224		
11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME		
Maryland USA			John Emmel		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
Marian Cawthorne (Cawthorne)			Yes 1961 - 1963		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
213-34-3248			Hospital Records		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Neuro. fibrillation</p> </div> <div style="width: 45%;"> <p>(B) Cerebrovascular dis. DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Hypertension</p> </div> </div>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 4-8-1970 to 4-8-1970 that (I) (we) last saw the deceased alive on 4-8-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
C. J. Limas, MD				4-8-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
CONSTANTIN J. LIMAS, MD				MERCY HOSP. BALTIMORE MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-11-70		Holy Rosary Cemetery	
24D. LOCATION (City, town, or county) (State)		25. DATE RECEIVED BY HEALTH DEPT.			
7301 German Hill Rd., Ba. Co., Md.		APR 10 1970			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
Charles S. Geiler		6224 Eastern Ave. Balto., 21224, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 3820	
B-420 70 3820 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Black Nathan		2. DATE AND HOUR OF DEATH 4-9-70 645 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Pleasant Manor Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Balto. Co. C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3409 Courtleigh Drive			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-82	9. AGE (In years last birthday) 88	10. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria	
13. FATHER'S NAME Louie		14. MOTHER'S MAIDEN NAME Anne			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-32-1840A		17. INFORMANT Mrs. Maurine Black	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9+250.9 (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Coronary occlusion sudden (B) DUE TO, OR AS A CONSEQUENCE OF: Gen. CV disease & CVA + hfx 2-26-70 (C) hemiparesis diabetes mellitus Myocardial Infarction 3-2-70			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4-8-70 19 to 4-9-70 19 that (we) last saw the deceased alive on 4-9-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE L.B. Scott M.D.				23B. DATE SIGNED 4-9-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/10/70		24C. NAME OF CEMETERY OR CREMATORY Har Zion Tifereth Israel Balto	
24D. LOCATION (City, town, or county) (State) MD		25A. DATE REC'D BY HEALTH DEPT. APR 10 1970			
25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR Edmund Levine & Son 9610 Ristow Rd			

Am. Rev. May

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BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) Edna McCommon (Virginia)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 4 70 12:24 am.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1537		6. SEX female 7. RACE colored 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-16-1890 10. AGE (in years lost birthday) 79 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Fazwell, Virginia		E. STREET AND NUMBER 2427 N. Dennison St.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Ward	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		15. MOTHER'S MAIDEN NAME Pocahontas Smith	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 226-40-0902	
18. INFORMANT Edna Webb ADDRESS Same		19. 412.41 CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 4/7/70	
24C. NAME OF CEMETERY or CREMATORY Oak Grove		24D. LOCATION (City, town, or county) (State) Wytheville Virginia	
25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		25B. NAME OF REGISTRAR James E. Taylor, M.D.	
25C. FUNERAL DIRECTOR William H. Phillips		ADDRESS 1727 N. Monmouth St.	



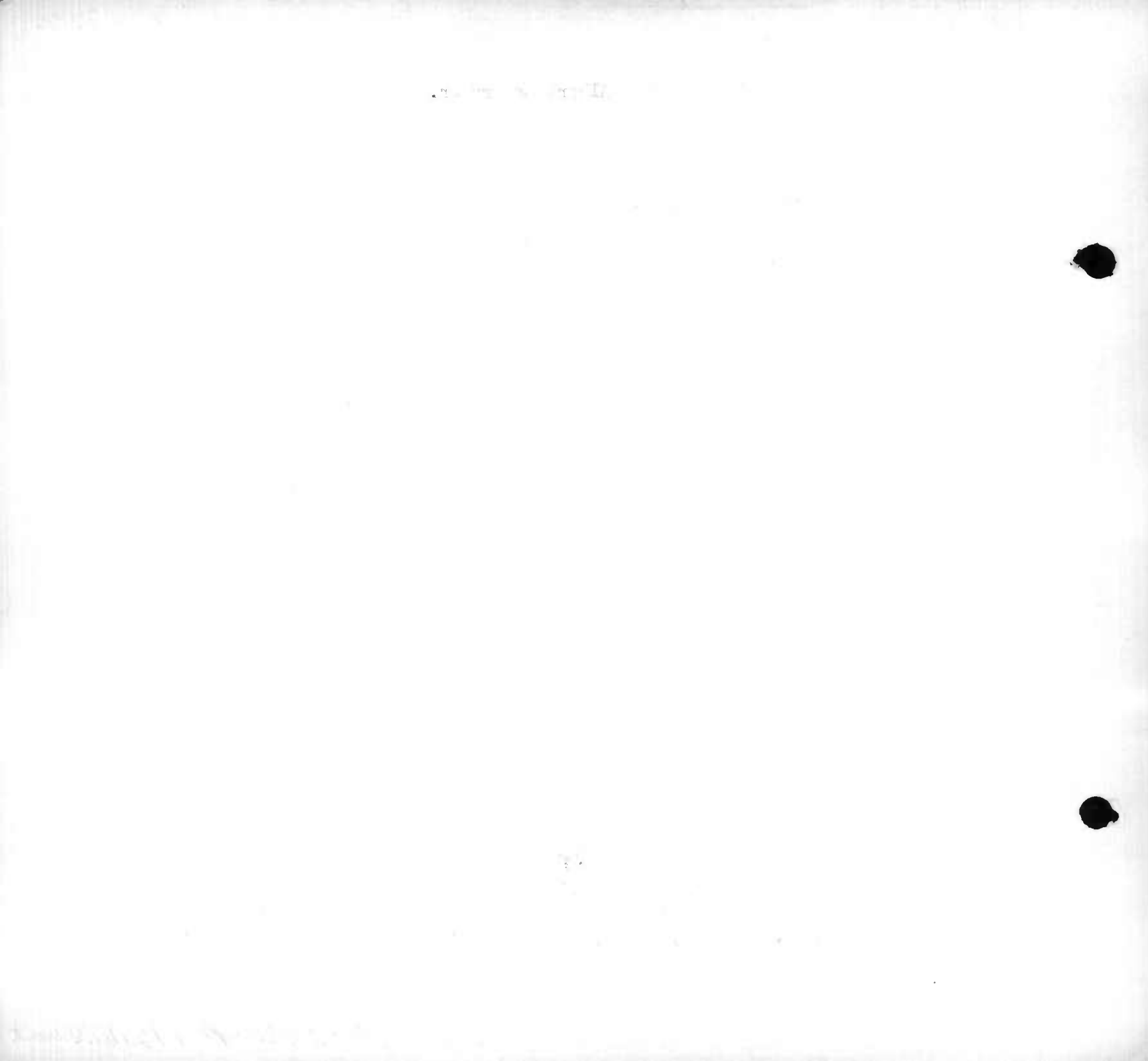
ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

DATE 10-10-2000 BY SP-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
L-520		70 3822		70 3822	
BIRTH NO. 70-05311		70 3822		70 3822	
1. NAME OF DECEASED (Type or Print) <i>Baby Boy Long</i>		2. DATE AND HOUR OF DEATH <i>4.5.70</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Albert Lowery Jr.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>The Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1538</i>		5. SEX <i>Male</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Johns Hopkins Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>3303 Springdale Avenue</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <i>3/28/70</i>		9. AGE (in years last birthday) <i>8</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Albert Lowery</i>	
14. MOTHER'S MAIDEN NAME <i>Rena Long</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Albert Lowery Jr.</i>		ADDRESS <i>Same</i>		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Coronation of the Aorta</i>	
19. DATE OF OPERATION <i>4.5.70</i>		20. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Coronation of Aorta</i>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22. I certify that (I) (this hospital) attended the deceased from <i>4.5.70</i> to <i>4.5.70</i> and that (I) (we) last saw the deceased alive on <i>4.5.70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23. SIGNATURE <i>C. W. Gehris, Jr.</i>		24. DATE SIGNED <i>4.5.70</i>	
25. DATE REC'D BY HEALTH DEPT. <i>APR 10 1970</i>		26. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		27. FUNERAL DIRECTOR <i>William S. Phillips</i>	
28. ADDRESS <i>1721 M. Mount</i>		29. ADDRESS <i>1721 M. Mount</i>		30. ADDRESS <i>1721 M. Mount</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 3823	
BIRTH NO. J-525		70 3823		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mary Ellen Jenkins			2. DATE AND HOUR OF DEATH 4-7-70 10 09 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> CERTIFICATE AMENDED <small>FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)</small> 4-30-70 Lutheran Hospital Sinai Hospital (DOA) </div>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1511		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3531 Denison Road		
5. SEX Female	6. RACE Negor	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/84	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Alexander Ennels		
14. MOTHER'S MAIDEN NAME Sarah F. Stewart			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 578-10-1795			17. INFORMANT Esther Johnson 3903 Dorchester Road		
18. 410.9 14250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Occlusion (B) Atherosclerotic C.V. Disease DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes Mellitus		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 1/2 hr. > 10 yrs. > 10 yrs.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1951 to Apr 7 1970 , that (I) was last saw the deceased alive on Apr 7 1970 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Garland Churchill MD			23B. DATE SIGNED 4-9-70		23C. PHYSICIAN'S NAME (Type) H. Garland Churchill
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/10/70		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. APR 10 1970		
25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Arlington S. Phillips		
ADDRESS 1727 N. Monroe Street					

4-30-70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 3824</u>	
BIRTH NO. <u>R-150 70 3824</u>		1. NAME OF DECEASED (Type or Print) <u>JAMES JOSEPH RUFFIN</u>		2. DATE AND HOUR OF DEATH <u>4/10/70</u> <u>5 am</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 UNIVERSITY HOSPITAL BALTIMORE, MARYLAND 21201</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>212 23</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>311 N. STRICKER ST.</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/20/04</u>	9. AGE (in years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FREIGHT HANDLER TRUCKING</u>			11. BIRTHPLACE (State or foreign country) <u>PETERSBURG VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>GLORIA ROSE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>215-01-7835</u>		17. INFORMANT <u>CHART CLORA RUFFIN</u> ADDRESS <u>311 N. STRICKER ST</u>
18. <u>530.44 1250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>PERFORATION OF ESOPHAGUS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>DIABETES MELLITUS</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>3/12 13/28/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PERFORATION OF ESOPHAGUS</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/5/70</u> 19 <u>70</u> to <u>4/10</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4/10</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Vicente R. Carag Jr. M.D.</u> DEGREE				23B. DATE SIGNED <u>4/10/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>VICENTE R. CARAG JR. M.D.</u> DEGREE				23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/14/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT AUBURN</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE</u>		24E. DATE REC'D BY HEALTH DEPT. <u>APR 13 1970</u>			
24F. NAME OF REGISTRAR <u>Robert E. Taylor</u>		24G. FUNERAL DIRECTOR <u>Franklin P. Hays</u>		24H. ADDRESS <u>638 N. BAYVIEW</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3825	
B-516 70 3825		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANDREW BUMBRAY		2. DATE AND HOUR OF DEATH 4/10/70 12:30 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1504	
FULL NAME OF HOSPITAL OR INSTITUTION 1820 W. North Av.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		5. SEX M 6. RACE B 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/24/86 9. AGE (In years lost birthday) 83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Picked chickens Self employed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Bumbray		14. MOTHER'S MAIDEN NAME Fannie Fletcher	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-20-3658		17. INFORMANT Jessie Bumbray (wife) ADDRESS same	
18. 4/10/70 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) myocardial Infarction 1 hour ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost, (B) Arterio-sclerotic Heart disease unknown		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 1 October 1969 to 4/10 1970 , that (I) (we) last saw the deceased alive on 4/10 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (didn't) view the body after death.			
23A. SIGNATURE D. W. STEWART, M.D.		23B. DATE SIGNED 4/10/70		23C. PHYSICIAN'S NAME (Type) D. W. STEWART, M.D.	
23D. ADDRESS 2300 Garrison Blvd.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-15-70	
24C. NAME OF CEMETERY OR CREMATORY Wattson National Cem.		24D. LOCATION (City, town, or county) (State) 5501 Gadwick Ave. Balt., Md.		25A. DATE REC'D BY HEALTH DEPT. APR 13 1970	
25B. NAME OF REGISTRAR E. J. Taylor, R.D.		25C. FUNERAL DIRECTOR Joseph A. Rhee		25D. ADDRESS 2222 W. North Ave.	

1820 W. North Ave. is Residence.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70

3826

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM SAVAGE		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 12 Year 70 Hour 1:38 a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month April Day 12 , Year 1970 Hour 1:38 a M.	
6. SEX Male 7. RACE Negro 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1512	
9. DATE OF BIRTH Sept. 24, 1916 10. AGE (In years, lost birthday) 53 11. BIRTHPLACE (State or foreign country) Northampton Co. Pa.		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY? U.S.		E. STREET AND NUMBER 3411 Shirley Ave.	
13. FATHER'S NAME George Lloyd		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician	
15. MOTHER'S MAIDEN NAME Maggie Parker		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 214-14-3623		18. INFORMANT Mr. Juanita Savage ADDRESS 2411 Shirley Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 4/12/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4/12/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-70	
24C. NAME OF CEMETERY OR CREMATORY Arhatas Mem. Park		24D. LOCATION (City, town, or county) (State) Arhatas (Baltimore) Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Rose E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Joseph L. Davis		ADDRESS 2222 W. Park Ave.	

UNITED STATES DEPARTMENT OF THE INTERIOR

Geological Survey

Washington, D.C.

Report of the Director

for the year ending June 30, 1904

Presented to Congress at the opening of the 58th Congress

January 3, 1905

By the Director

Charles D. Walcott

Chief of the Geological Survey

Washington

Printed by the Government

Printer: J. M. Smith

Geological Survey, Washington, D.C.

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Published by the Geological Survey, Washington, D.C.

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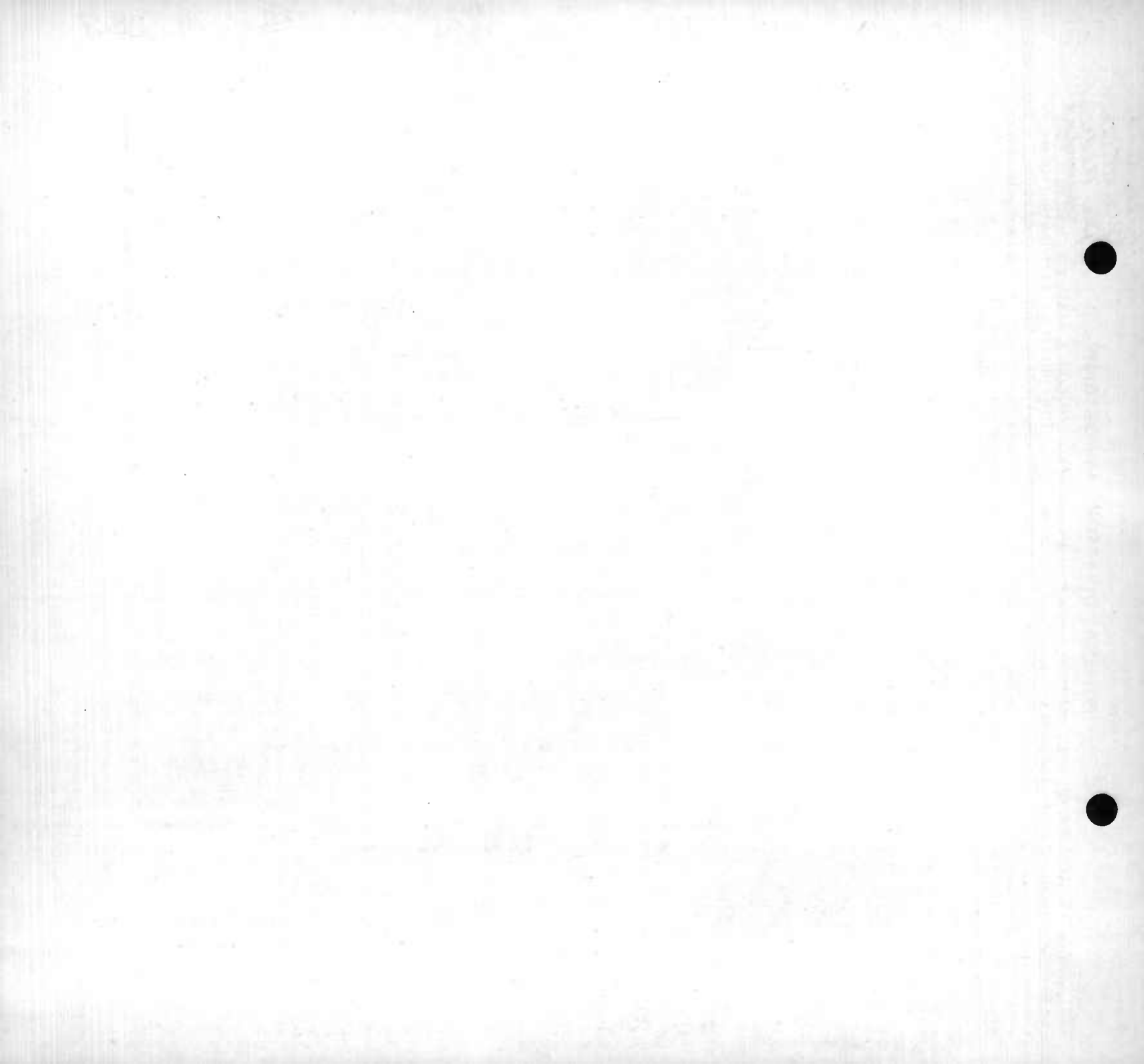
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 3827

BIRTH NO.		1. NAME OF DECEASED (Type or Print) REGINA BISHOP		2. DATE AND HOUR OF DEATH 4-9-70 1045 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2758		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER Loch Raven Apts., Apt. C 1629 Waverly Way Balto. 21212	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-12-28	9. AGE (In years last birthday) 41	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) UNK MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph		14. MOTHER'S MAIDEN NAME Mary Ann MARIANNA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 064-12-5953		17. INFORMANT 4940 Eastern Avenue BCH Records - Balto., Md. 21224	
18. 200.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEN RETICULUM SARCOMA OF STOMACH (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ASPIRATION PNEUMONIA 1 DAY	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 12-5-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RETIC. SARC. STOM.		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-26 1969 to 4-9 1970, that (I) (we) last saw the deceased alive on 4-9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William E. Powers, JR., M.D. DEGREE		23B. DATE SIGNED 4-9-'70		23C. PHYSICIAN'S NAME (Type) WILLIAM C. POWERS, JR., M.D. DEGREE	
23D. ADDRESS 4940 Eastern Avenue Balto., Md. 21224		24. BURIAL CREMATION, REMOVAL (Specify) BURIAL 4/13/70			
24B. DATE 4/13/70		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY		24D. LOCATION (City, town, or county) (State) DUNDALK MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR J. E. Fisher, JR.		25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS 5 CHESTER	

FUNERAL DIRECTOR: IMPORTANT

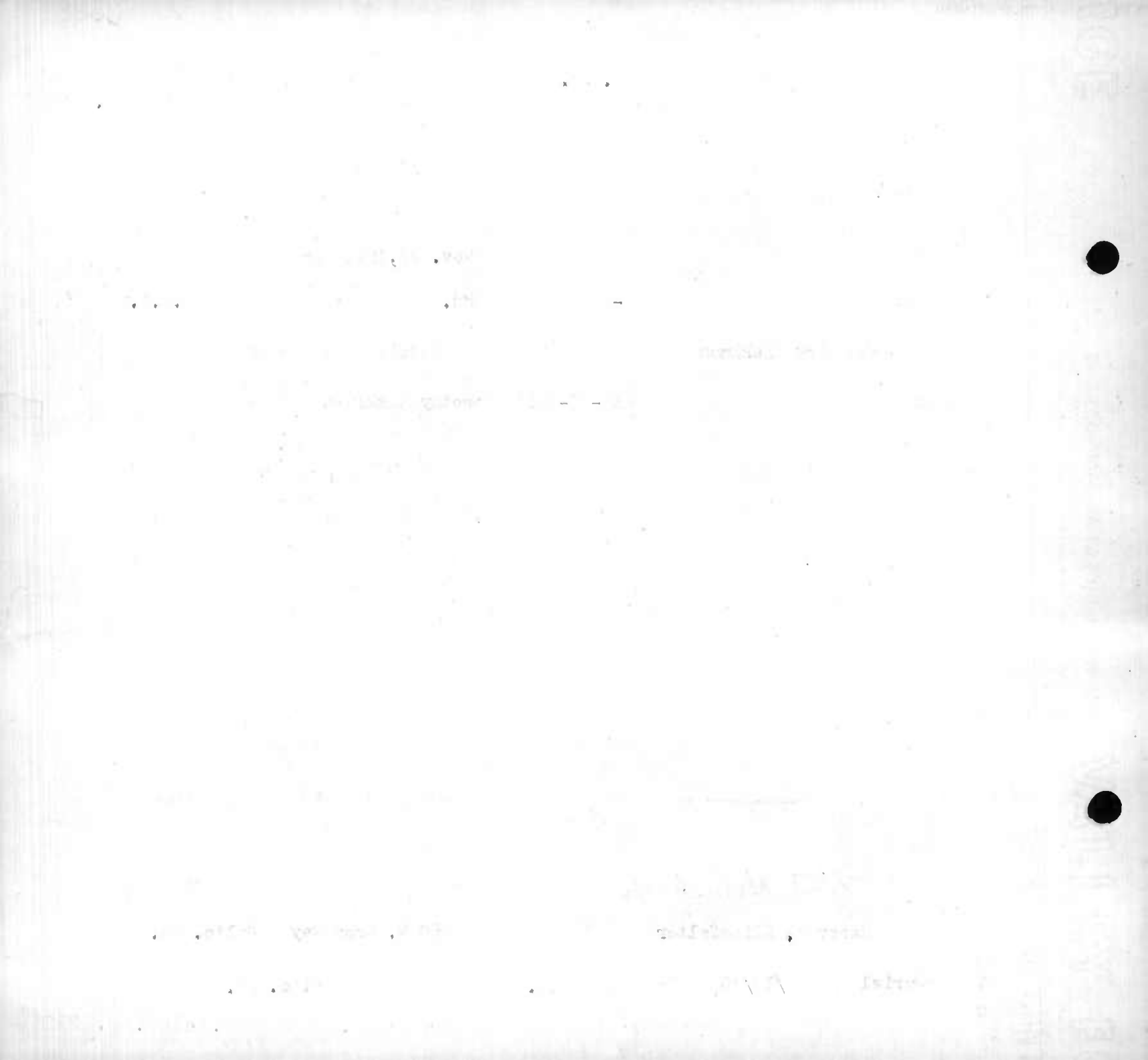
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3828	
BIRTH NO. 17-255 70 3828		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MISKIMON, KIRK W. Sr.		2. DATE AND HOUR OF DEATH April 9, 1970 1145 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2741	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 5005 Crosswood Ave.	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1914
		9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Md.
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kirk Miskimon		14. MOTHER'S MAIDEN NAME Bessie Shaughnessy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-03-3917	17. INFORMANT ADDRESS Dorothy Miskimon same
18. 450 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
MEDICAL CERTIFICATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from September 1953 to present 19 70 , that (I) (we) last saw the deceased alive on March 9 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE H. F. Klinefelter		23B. DATE SIGNED 4/10/70	
23C. PHYSICIAN'S NAME (Type) Harry F. Klinefelter		23D. ADDRESS 550 N. Broadway Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/13/70	24C. NAME of CEMETERY or CREMATORY Parkwood Cem.	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970	25B. NAME of REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

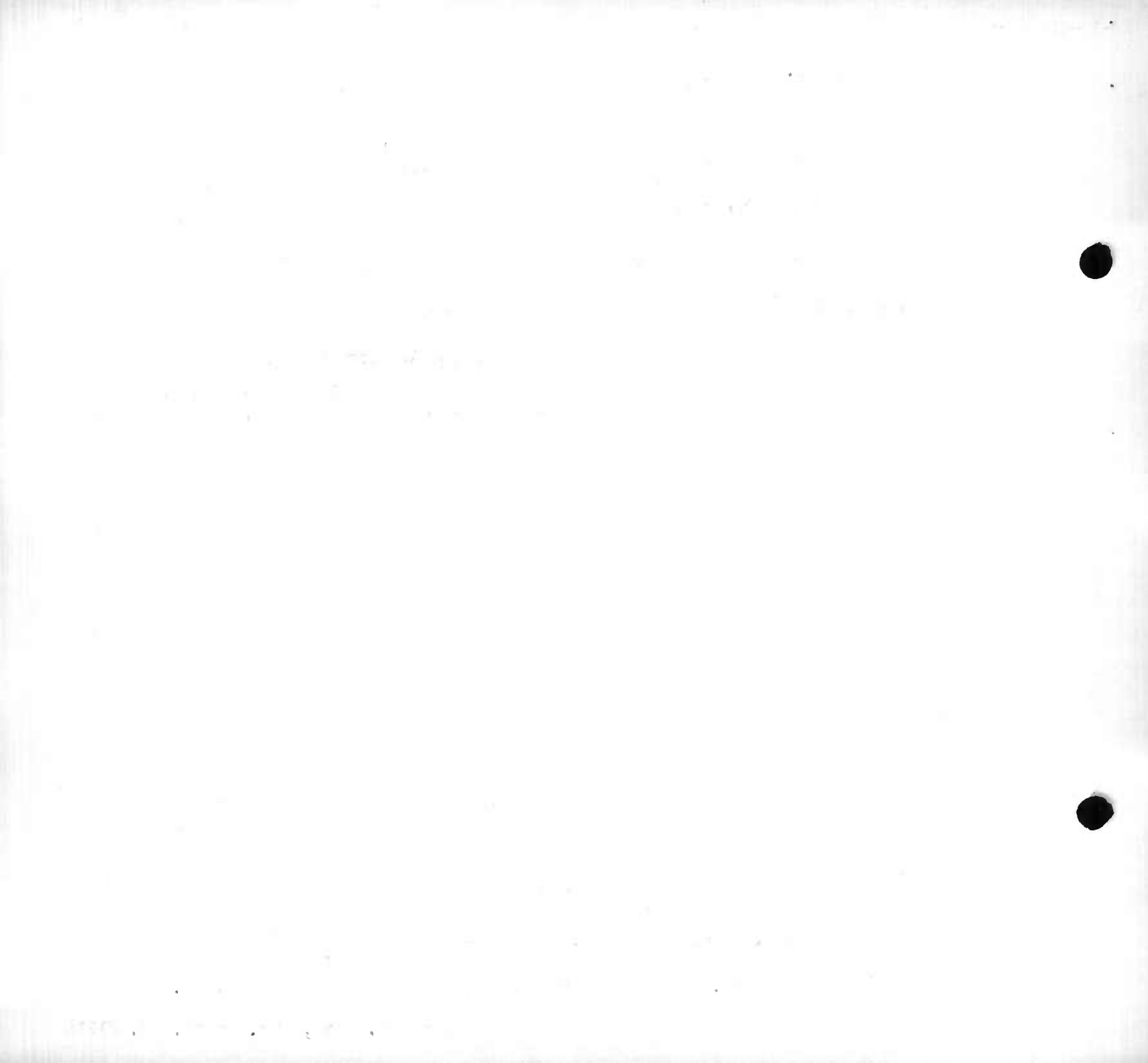
G-656		70 3829		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3829	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GERMERSHAUSEN, HENRY				2. DATE AND HOUR OF DEATH APRIL 9, 1970 12:15P^M			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE, MD. 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND (COUNTY BALTIMORE) C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER MAIDEN CHOICE KANKE LANE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08/01/83	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10B. KIND OF BUSINESS OR INDUSTRY PRINTING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH GFRMERSHAUSEN DEC'D				14. MOTHER'S MAIDEN NAME CHRISTINA (SCHENE) DEC'D			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-8137		17. INFORMANT ADDRESS BALTIMORE, MD. 21229 ST. AGNES RECORDS-WILKENS & CATON AVES			
18. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). strangled may. hernia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 4/9		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Resection gastric ulcers		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/8/70 19 to APRIL 9, 19 70 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 9, 19 70 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jamie V. del Pilar				23B. DATE SIGNED 4/9/70		23C. PHYSICIAN'S NAME (Type) DR. JAMIE DEL PILAR MD	
23D. ADDRESS BALTIMORE, MD. 21229 ST. AGNES HOSPITAL-WILKENS & CATON AVES.				23E. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balt. Md. 21214			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/11/70.		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Vailley		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balt. Md. 21214			

2705- Latona Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

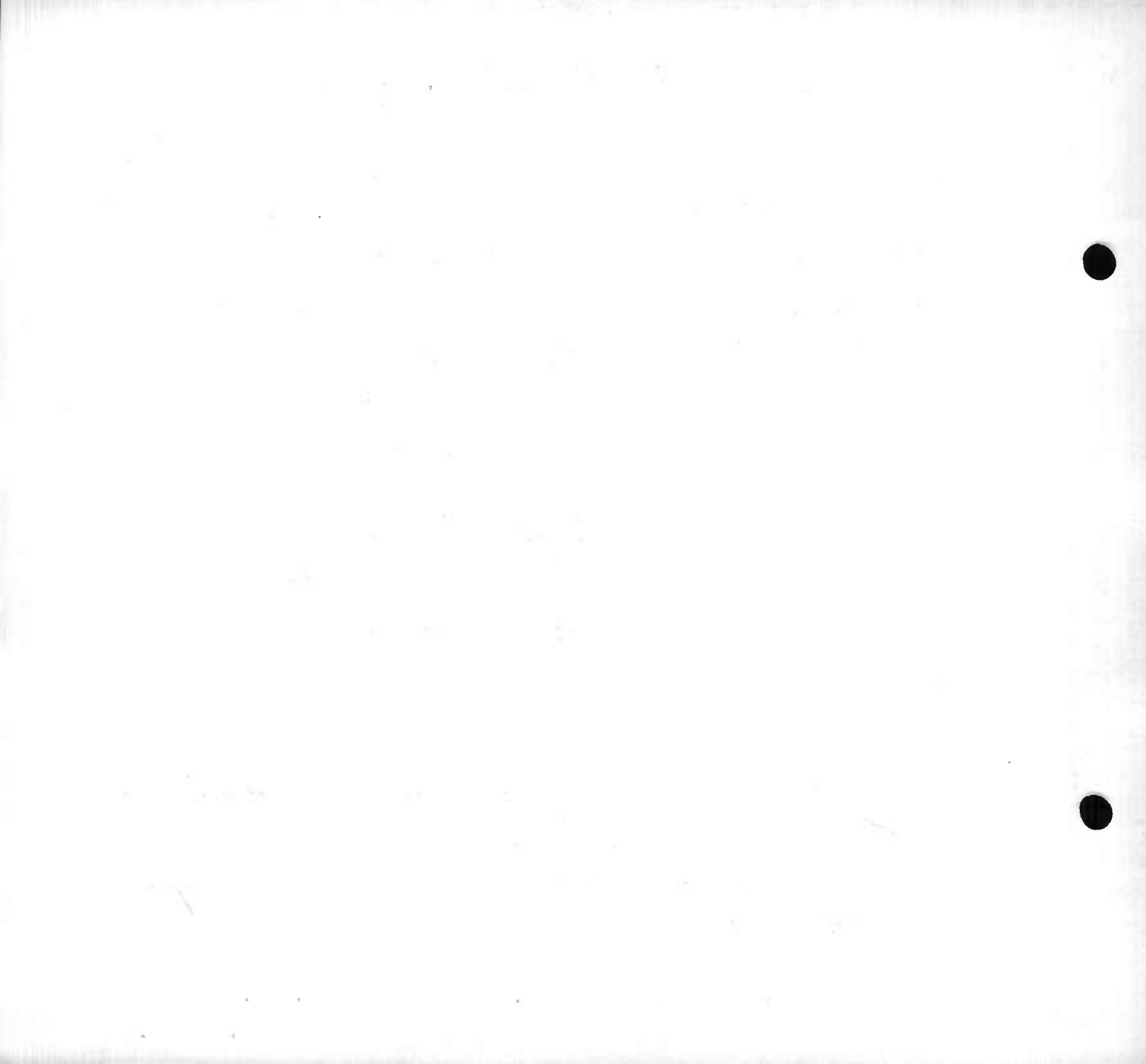
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) ANN I. LECUYER		2. DATE AND HOUR OF DEATH 4/6/70 5:20 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland, Baltimore B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 31 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F		6. RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-13-89	
9. AGE (In years last birthday) 81		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicholas White		14. MOTHER'S MAIDEN NAME Mary Ann W Wilson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-8706 A	
17. INFORMANT 4940 Eastern Avenue BCH-Records Baltimore, Maryland 21224		ADDRESS	
18. 786 X 1 Y 23-0-9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Sepsis - Bilateral DUE TO, OR AS A CONSEQUENCE OF: (B) Pneumonia + Urinary Tract Infection DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DIABETES MELLITUS		20. DATE OF OPERATION 2	
21. CONDITION FOR WHICH OPERATION WAS PERFORMED		22. AUTOPSY? (Yes or No) NO	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
29. HOW DID INJURY OCCUR?			
30. I certify that (I) (this hospital) attended the deceased from April 6 19 70 to April 6 19 70 that (I) (we) lost saw the deceased alive on April 6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
31. SIGNATURE Dale N. Schumacker M.D.		32. DATE SIGNED 4/6/70	
33. PHYSICIAN'S NAME (Type) Dale N. Schumacker MD.		34. ADDRESS BCH- 4940 Eastern Avenue Baltimore, Maryland 21224	
35. BURIAL CREMATION, REMOVAL (Specify) Burial		36. DATE 4/9/70.	
37. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		38. LOCATION (City, town, or county) (State) Baltimore, Md.	
39. DATE REC'D BY HEALTH DEPT. APR 13 1970		40. NAME OF REGISTRAR P. A. E. Fisher, M.D.	
41. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-660		70 3831		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3831	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		BREWER SYLVIA B.		2. DATE AND HOUR OF DEATH		APR 8, 1970 2:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL 44 HOSPITAL				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md. BALTIMORE		7306	
5. SEX FEMALE				6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01-11-08	
9. AGE (In years, last birthday) 62				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME HENRY SHIREY				14. MOTHER'S MAIDEN NAME MARY J. HOLSTEIN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT PLEASANT W. BREWER			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 070 X I POSTNECROTIC CIRRHOSIS OF THE LIVER				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: VIRAL HEPATITIS					
				(B) DUE TO, OR AS A CONSEQUENCE OF: HEPATIC COMA					
				(C) DESOXYHEPATEAL VARIANTS					
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 02-10-1970 to 4-8-70 that (I) (we) lost her the deceased alive on 4/7-1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. P. MIRON				23B. DATE SIGNED 4/8-70					
23C. PHYSICIAN'S NAME (Type) J. P. MIRON				23D. ADDRESS UMH					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/11/70		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970				25B. NAME OF REGISTRAR Leonard		25C. FUNERAL DIRECTOR Ruck Inc. Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3832	
BIRTH NO. G-60 70 3832		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		MARIE GRAEFF		2. DATE AND HOUR OF DEATH April 6, 1970. 4:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 2908 Glenmore Avenue		A. STATE Md.		B. COUNTY 2706	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2908 Glenmore Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1889.	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Kramer			
14. MOTHER'S MAIDEN NAME ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-01-6836A		17. INFORMANT Mrs. Doris M. George		ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Coronary Thrombosis HSCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day year					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 19 69 to April 6 1970, that (I) (we) lost saw the deceased alive on 3/31 1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Geo H. Beck		23B. DATE SIGNED 4/7/70		23C. PHYSICIAN'S NAME (Type) George H. Beck MD	
23D. ADDRESS 6012 HANFORD ROAD BALTO MD 21214		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 4/9/70.		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT APR 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

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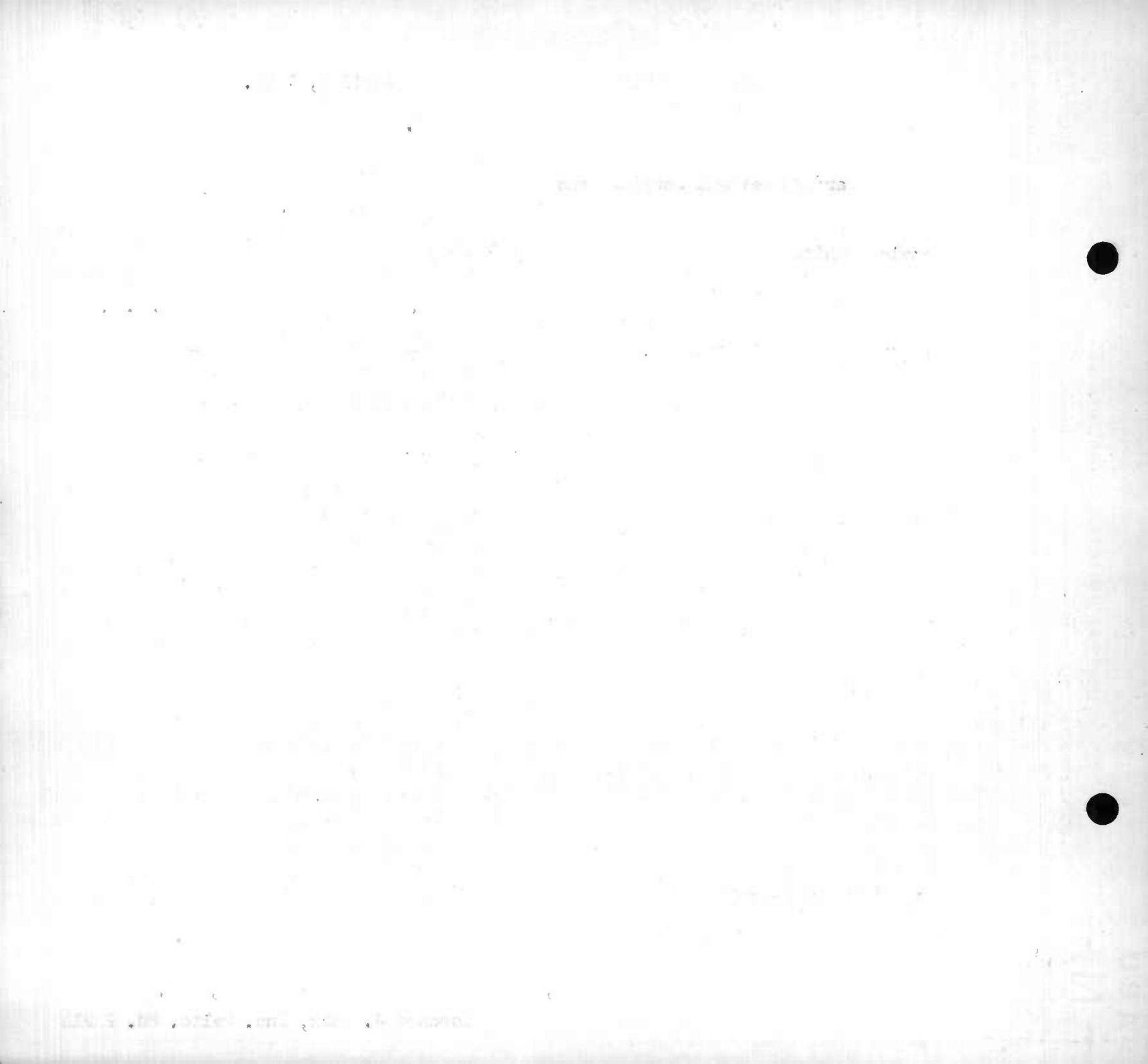
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3833	
<div style="display: flex; justify-content: space-between;"> <i>L-152</i> 70 3833 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANNA LOVING		April 9, 1970. <i>6:30 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Harford Gardens Nursing Home			A. STATE Md.		
			B. COUNTY 2744		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3613 White Ave.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12/29/1884	85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
At Home				Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
- Sommers			-		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		-		Catherine Loving same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
412.4 + 1250.9 Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellitus Condition after intestinal cancer			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			many years		
			6 months		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/19 1964 to 4/9 1970 , that (I) (we) last saw the deceased alive on 3/12 1970 and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE, SIGNED	
<i>Hans A. Oetter</i>				4/9/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Hans A. Oetter		5600 Harford Road Balto. Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4/13/70		Baltimore,	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 13 1970		Robert E. Fisher, MD.		Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 3834</u>	
L-550 <u>70 3834</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>JESSE B. LEHMAN</u>		2. DATE AND HOUR OF DEATH <u>04-08-70</u> <u>2:15 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE UNION MEMORIAL HOSPITAL</u> <u>44</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>U.S.A.</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5211 WALTHER BLVD.</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06-03-85</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT-Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>
13. FATHER'S NAME <u>ANSEL LEHMAN.</u>		14. MOTHER'S MAIDEN NAME <u>ESTHER HIRSCH</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Never</u> No		16. SOCIAL SECURITY NO. <u>218-32-2506</u>	17. INFORMANT <u>Mrs. Nellie Lehman</u> <u>H. M. S. L.</u>
18. <u>1990</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIORESPIRATORY ARREST.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CALCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>LEFT HEMIPLASIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>03-30-70</u> 19 <u>70</u> to <u>04-08</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>04-08</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Yasumasa Yamasaki M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>04-08-70</u>
23C. PHYSICIAN'S NAME (Type) <u>YASUMASA YAMASAKI M.D.</u>		23D. ADDRESS <u>33RD AND CALVERT STS BALTO MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/11/70.</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1970</u>	25B. NAME OF REGISTRAR <u>Robert J. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>	

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MERCHANT-
ANSEL LEHMAN
MARYLAND
ESTHER HIRSCH
HIMSELF

(ARRESTED BY POLICE)

LEIT HENRIETTA
CALCULATED

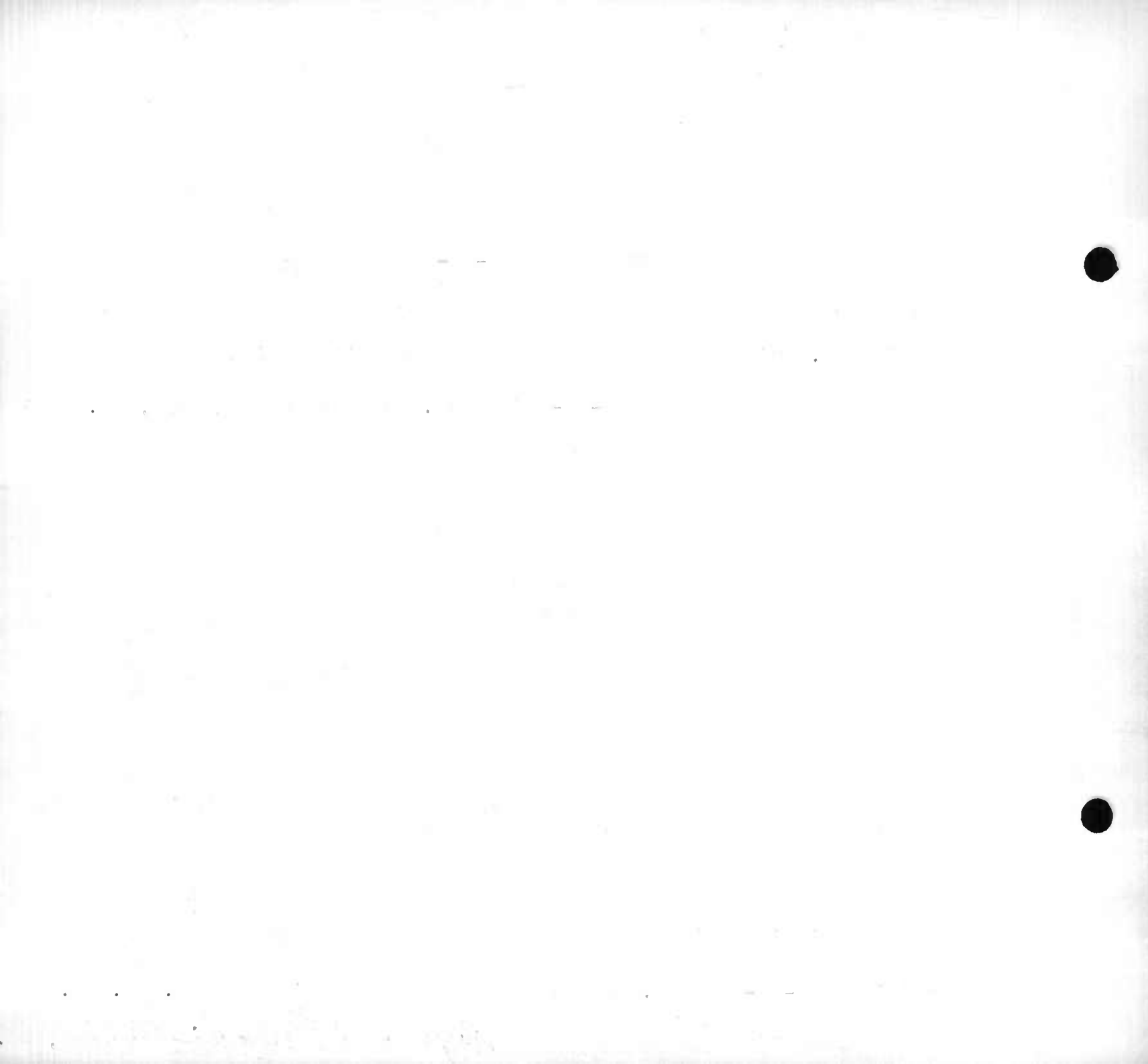
CO-68
CO-30-8
CO-68

YASUNAGA YAMAZAKI
M.D. 33RD AND CARPENT ST. BOSTON
CO-68

FUNERAL DIRECTOR: IMPORTANT

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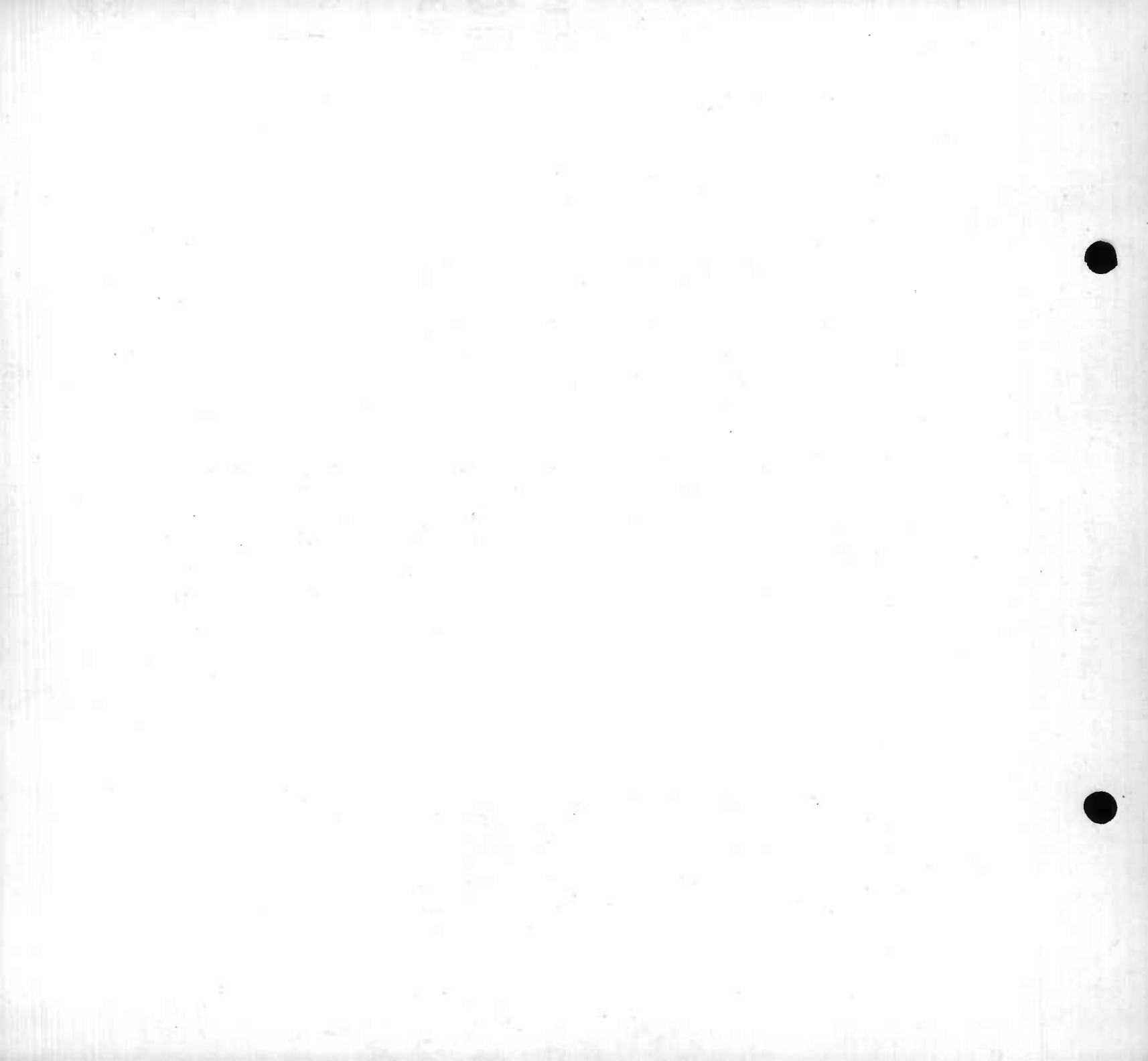
BIRTH NO. 70 3835		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3835	
1. NAME OF DECEASED (Type or Print) Smith, Sr. Clifford H			2. DATE AND HOUR OF DEATH 4/7/70 11 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 5300		
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp.		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2739 Arbutus Ave.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-25-90	9. AGE (in years last birthday) 80 YEARS
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles E. Smith			
14. MOTHER'S MAIDEN NAME Cecelia Smith		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 218-12-8470		17. INFORMANT Mrs. Ivy Brooks Thurmont, Md. RD 2			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PNEUMONIA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: INTRACEREBRAL BLEED		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: HASCD		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II			COPD gastroic and duodenal ulcers		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/3 19 70 to 4/7 19 70 that (I) (we) last saw the deceased alive on 4/7 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William Eric Lohr, M.D.			23B. DATE SIGNED 4/8/70		23C. PHYSICIAN'S NAME (Type) William Eric Lohr
23D. ADDRESS So. BALD. GEN. HOSP.			23E. FUNERAL DIRECTOR Raymond E. Creager		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-11-70		24C. NAME OF CEMETERY or CREMATORY Mt. Moriah Cemetery	
24D. LOCATION Foxville Fred. Co. Md.		24E. DATE REC'D BY HEALTH DEPT. APR 13 1970			
24F. NAME OF REGISTRAR Robert E. Jolley		24G. ADDRESS Thurmont, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-632 70 3836		BALTIMORE CITY HEALTH DEPARTMENT		70 3836	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John Henry Curtis</i>		2. DATE AND HOUR OF DEATH <i>4/11/70 9:30p M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>33 Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>ANNE ARUNDEL</i>		C. CITY OR TOWN <i>ANNAPOLIS</i> D. INSIDE CITY LIMITS? <i>YES</i> <input type="checkbox"/> <i>NO</i> <input type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>N</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>2-25-12</i>	
13. FATHER'S NAME <i>John Henry Curtis Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Simmons</i>		9. AGE (In years last birthday) <i>58</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
17. INFORMANT <i>Martha Curtis Edgewater Mc</i>		ADDRESS		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
18. <i>199.1</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiorespiratory arrest</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Secondary to squamous carcinoma of stomach and pancreas and upper GI. bleeding.</i>			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from <i>4/11/70</i> to <i>4/11/70</i> , that we (we) last saw the deceased alive on <i>4/11/70</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Loren G. Lipson MD</i>		23B. DATE SIGNED <i>4/11/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Loren G. Lipson MD</i>	
23D. ADDRESS <i>Johns Hopkins Hospital, Baltimore</i>		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23F. ATTENDING PHYS. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-16-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Hope Memorial</i>	
24D. LOCATION (City, town, or county) <i>Edgewater</i>		24E. STATE <i>MD</i>		24F. FUNERAL DIRECTOR <i>William Beese</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 13 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. ADDRESS <i>William Beese</i>	



C-455

70 3837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 3837

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Donald Coleman (COLEMAN)

2. DATE AND HOUR OF DEATH

4/9/70

4⁴⁰ A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospital
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Kent Co. 64-00

C. CITY OR TOWN

Rockhall

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

Rockhall, Maryland 21661

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

11-27-37

9. AGE (in years
last birthday)

32

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Butcher shop

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME

Madison Coleman

14. MOTHER'S MAIDEN NAME

Beatrice Bennett

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215-38-0458

17. INFORMANT

BCH Records: 4940 Eastern Avenue
Baltimore, Maryland 21224

18. 207.0 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Sepsis

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8 mo

1 da

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/30 1970 to 4/9 1970
that (II) (we) last saw the deceased alive on 4/9 1970 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (II) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Riley M.D.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4/9/70

23C. PHYSICIAN'S
NAME (Type)

David J. Riley, M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospital
4940 Eastern Ave., Balto., Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/12/70

24C. NAME OF CEMETERY or CREMATORY

Wesley Chapel Cem.

24D. LOCATION

Rock Hall, Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 13 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

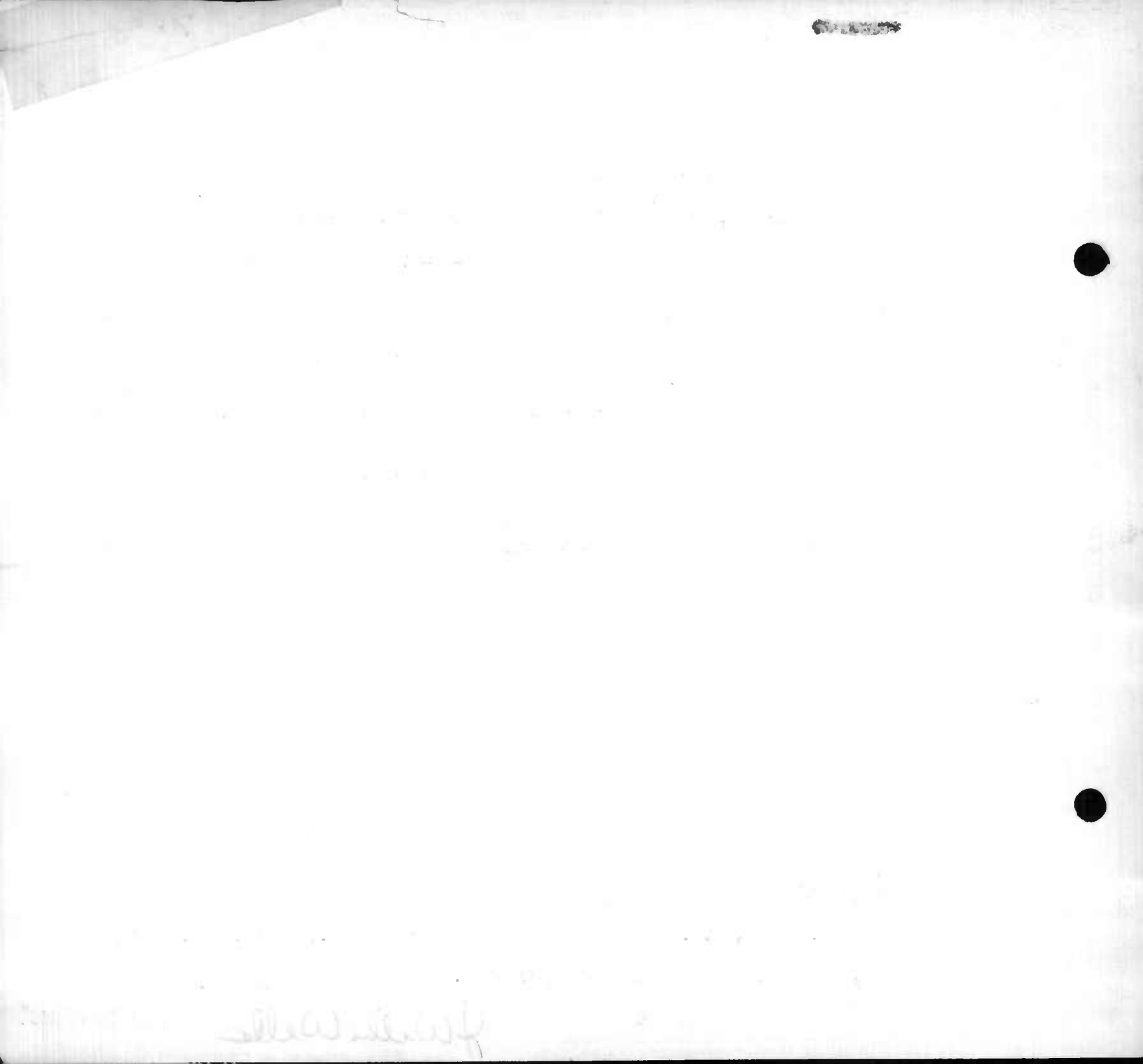
J. Wells Wells

ADDRESS

Chestertown, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO.

70 3838

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CONRAD JOSEPH GRANT

2. DATE AND HOUR OF DEATH

April 9, 1970

1:55

P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

US Public Health Service Hospital
3100 Wyman Park Drive

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Md.

Montgomery

6500

C. CITY OR TOWN

Silver Spring

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

11097 Grandview Apts. (Ave)

5. SEX

6. RACE

M

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

7/3/31

9. AGE (In years lost birthday)

38

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Contractor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

DC

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Bernard Grant

14. MOTHER'S MAIDEN NAME

Dorothy Jordan

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

USN

1954-1957

16. SOCIAL SECURITY NO.

579-40-6583

17. INFORMANT

ADDRESS

Records- US PHS Hospital, Balto, Md.

1B.

1929

I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Astrocytoma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

yrs

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I/this hospital) attended the deceased from Jan. 26 19 70 to Apr. 9 19 70, that (I/we) lost saw the deceased alive on Apr. 9 19 70 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did) (did not) view the body after death.

23A. SIGNATURE

Peter J. Philpott MD

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

4/9/70

23C. PHYSICIAN'S NAME (Type)

Peter J. Philpott, Surg (R)

DEGREE

23D. ADDRESS

US PHS Hospital, Balto, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-13-70

24C. NAME OF CEMETERY or CREMATORY

Mt Olivet Cemetery

24D. LOCATION

(City, town, or county)

(State)

Washington, D. C.

25A. DATE REC'D BY HEALTH DEPT.

APR 13 1970

25B. NAME OF REGISTRAR

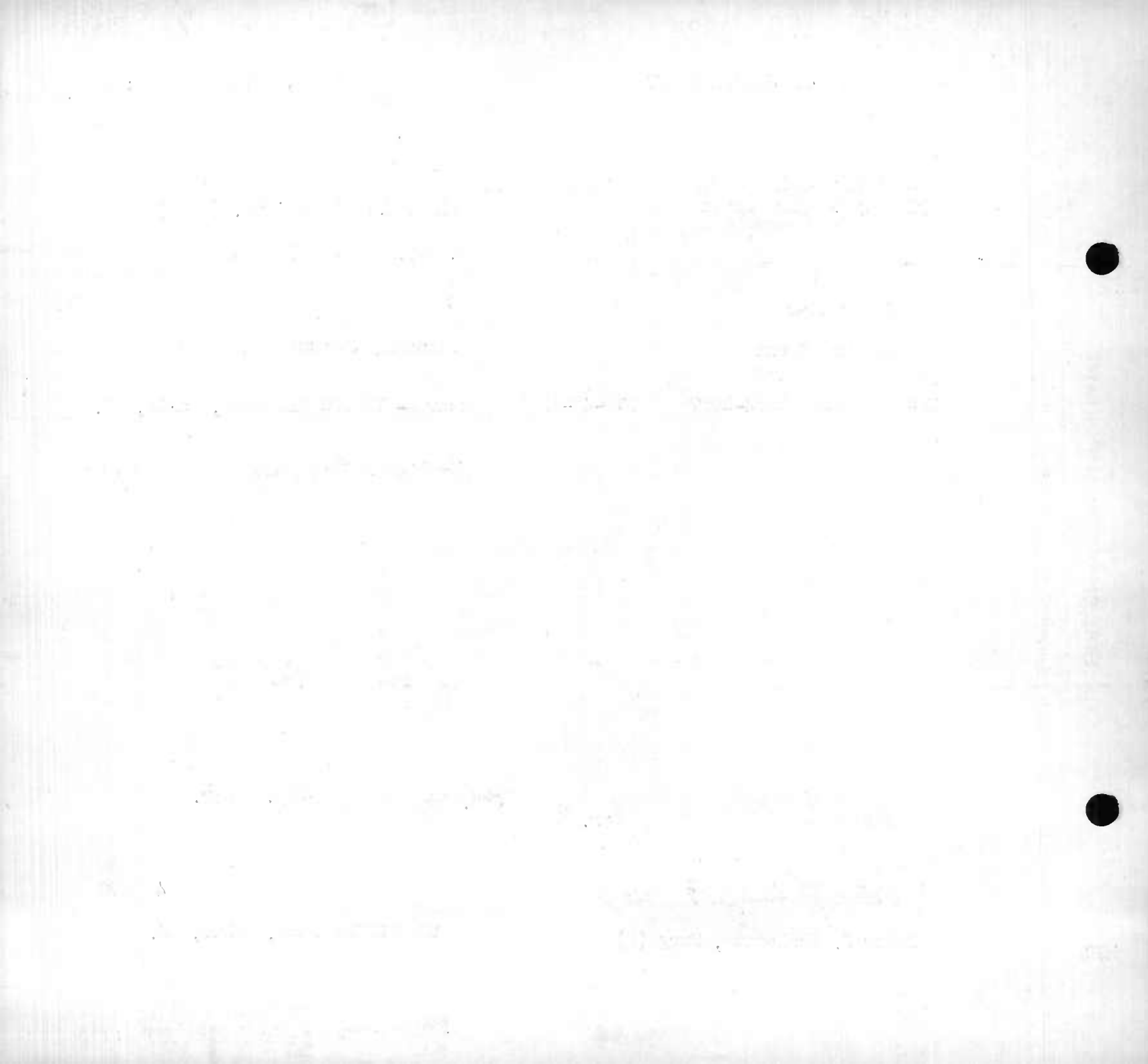
Peter J. Philpott, MD

25C. FUNERAL DIRECTOR

Francis J. Collins

ADDRESS

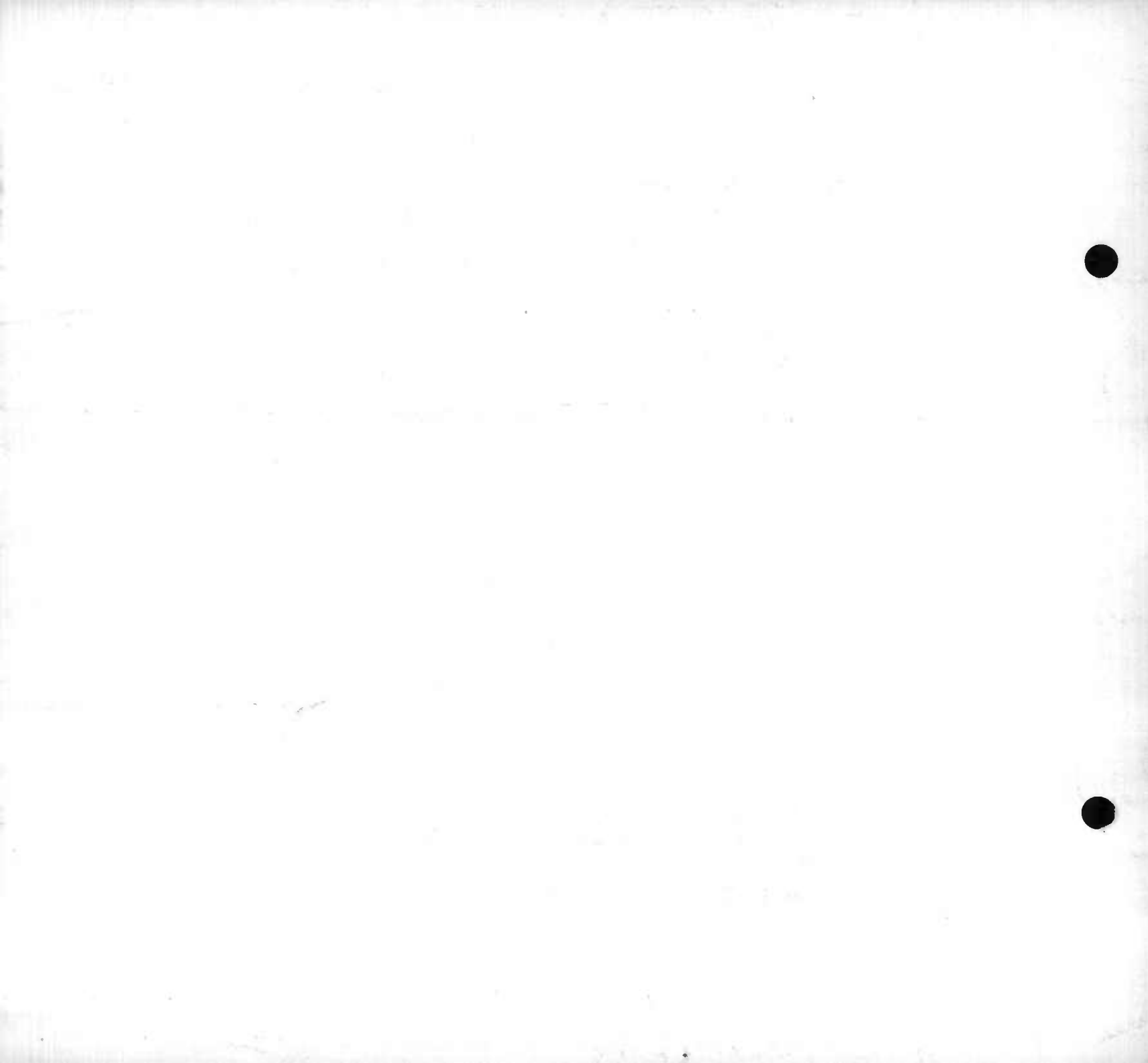
500 University Blvd. W. Silver Spring, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-625 70 3839				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3839	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) HOWARD GARRISON		2. DATE AND HOUR OF DEATH 4-9-70 125 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTO.		5. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTO. GENERAL 43				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1161 HAMBURG ST.	
5. SEX MALE	6. RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-01	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY C.T. Brandt Inc.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Archie bald Garrison				14. MOTHER'S MAIDEN NAME Mary Waterbagen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 213-10-0099		17. INFORMANT ADDRESS Myrtle Garrison 1161 Hamburg St.			
18. 4109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac & Respiratory Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumococcal Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (C) ASCVD				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS 1 WEEK 2 WEEKS YEARS			
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/24 19 70 to 4/9 19 70 that (I) (we) last saw the deceased alive on 4/9 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald M. Wood				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-10-70	
23C. PHYSICIAN'S NAME (Type) DONALD M. WOOD MD				23D. ADDRESS South Balto. Gen Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) 2930 Frederick Ave. Balto. Md	
25A. DATE RECEIVED BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR James E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schweinsberg Fun. Serv 1126 N. Cross St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3840</u>	
L-520 <u>70 3840</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) AGNES G. LONG			2. DATE AND HOUR OF DEATH APRIL 9, 1970 6:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2553		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2002 BREITWERT AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 10 82	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME PETER J BECK		14. MOTHER'S MAIDEN NAME M. ANNA RIPLE		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214 40 4545		17. INFORMANT Mr. John O. Beck, 2004 Breitwert Ave. 21230	
		18. 4369 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure Pneumonia C.V.A.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES DISEASES OR CONDITIONS, If any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 8 1970 to APRIL 9 1970 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 9 1970 and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>Zaheer-Kahn</i>			23B. DATE SIGNED 04 09 70		
23C. PHYSICIAN'S NAME (Type) ZAHEER-KAHN			23D. ADDRESS ST AGNES HOSPITAL BALTO MD 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-1970		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>[Signature]</i>	
				ADDRESS 4107 Wilkerson Ave.	

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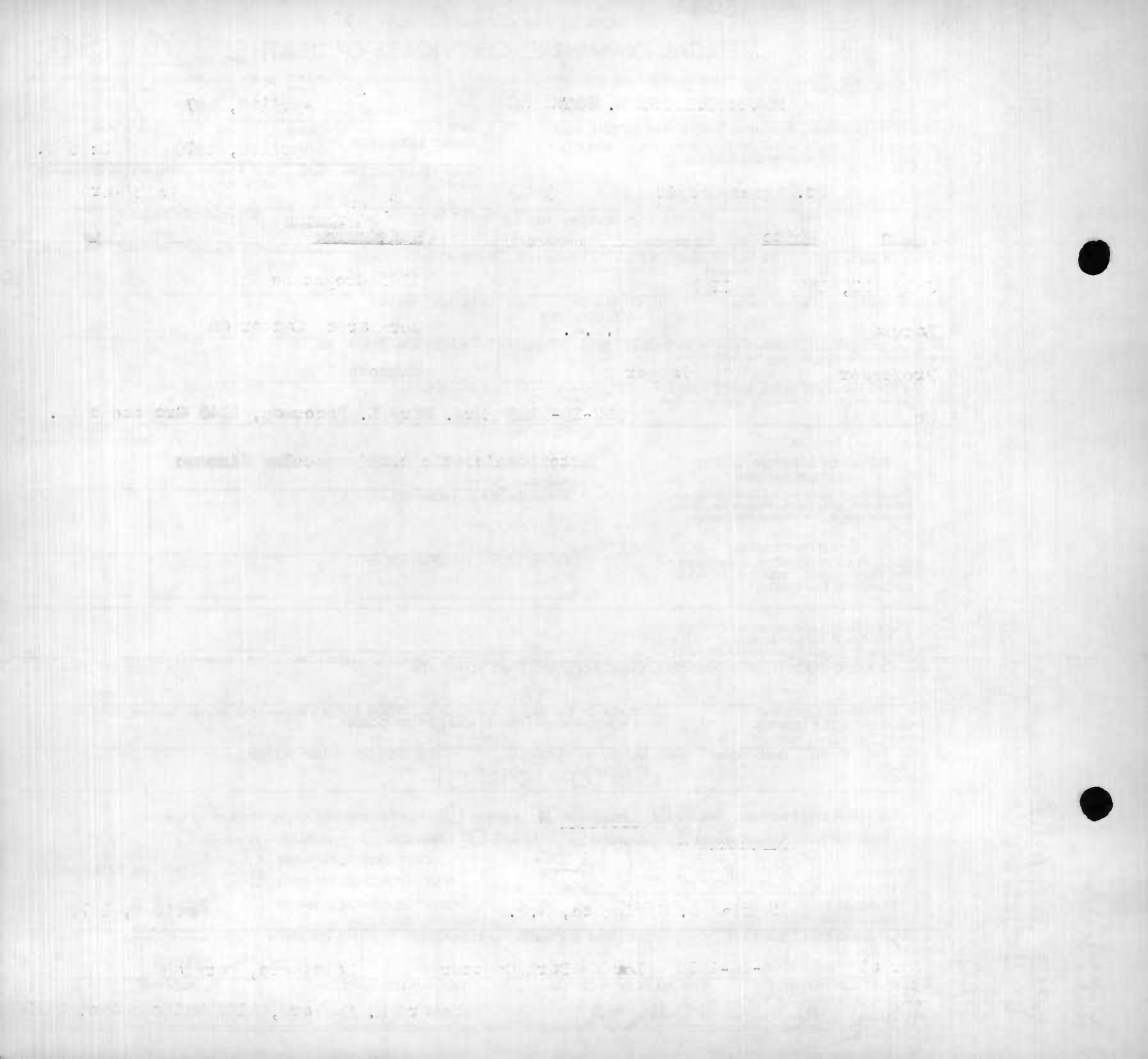
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3841

BIRTH NO.

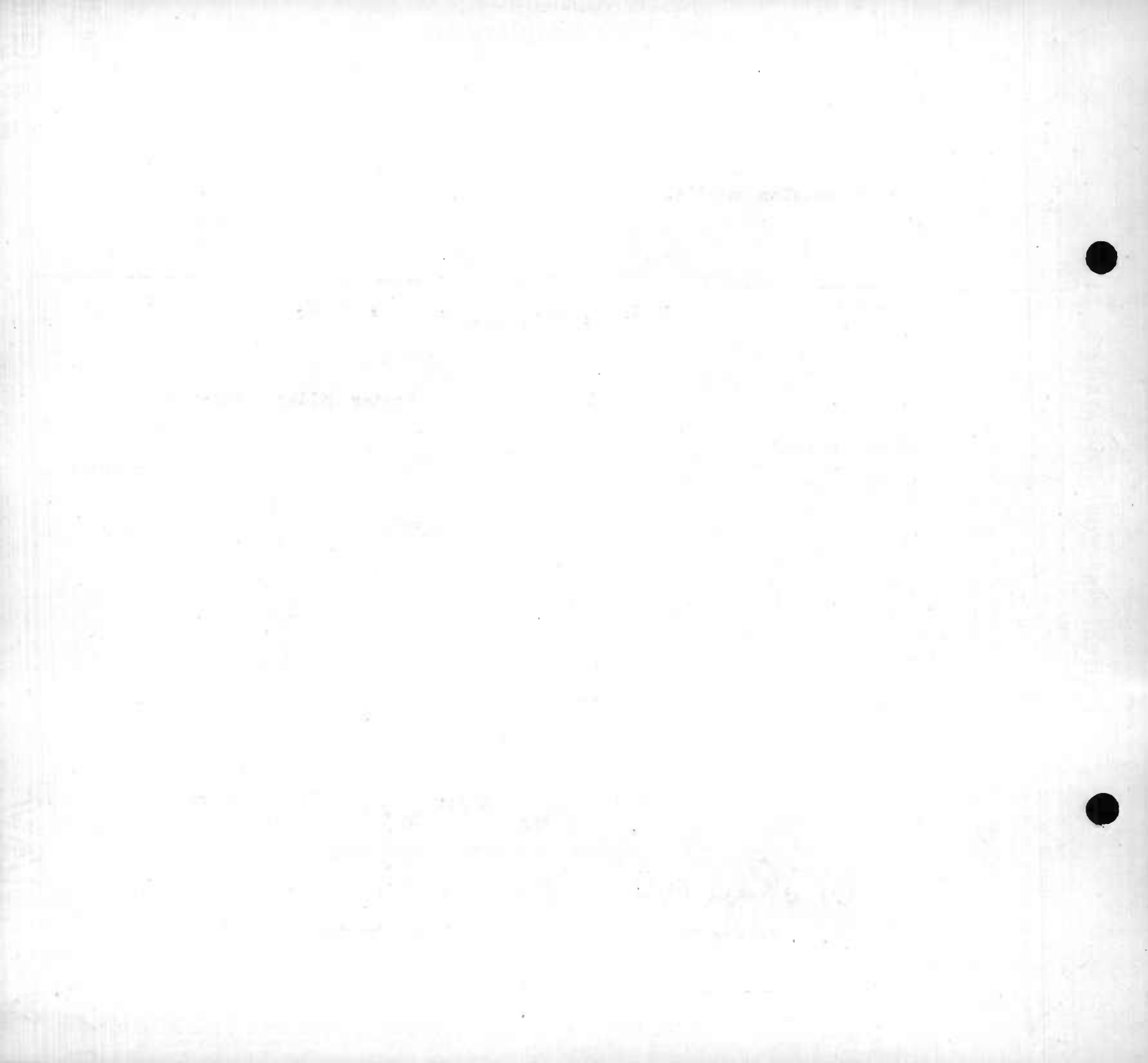
1. NAME OF DECEASED (Type or Print) MAX RATTERMANN B. RATERMAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour April 8, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 8, 1970 8:45 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH July 22, 1893		10. AGE (In years lost birthday) XX 76 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor		14B. KIND OF BUSINESS OR INDUSTRY Lawyer	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 322-28-9189		18. INFORMANT Mrs. Mary L. Ratterman, 1245 Greystone Rd.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB-UTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 9, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-1970	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

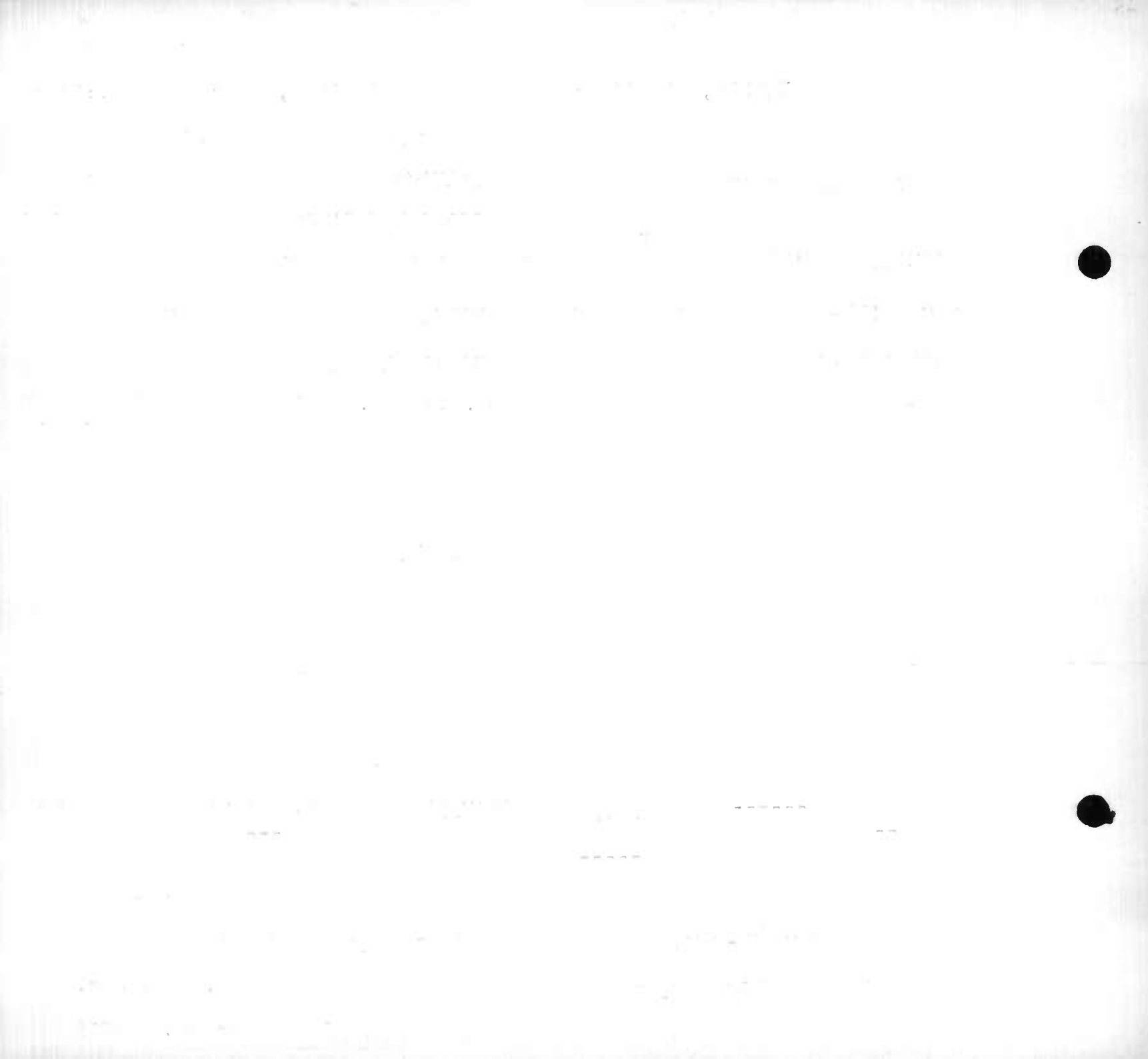
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 3842	
<div style="display: flex; justify-content: space-between;"> M-460 70 3842 </div>					
1. NAME OF DECEASED (Type or Print) Florence MILLER			2. DATE AND HOUR OF DEATH 6 April 70 4:15 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital			A. STATE Maryland B. COUNTY Balto.co. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 18 Compass Road 21220		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/3/00	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Nursery School	11. BIRTHPLACE (State or foreign country) Tyrone, Penna.		12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME JOHN SPRANKLE			14. MOTHER'S MAIDEN NAME LAURA ECKERT		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-5350	17. INFORMANT ADDRESS Foster Miller (Husband)		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
I 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CVA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			4 hours many years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6 Apr 1970 to 6 Apr 1970 , that (I) (we) last saw the deceased alive on 6 Apr 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. J. Rogers MD				23B. DATE SIGNED 6 Apr 70	
23C. PHYSICIAN'S NAME (Type) W. J. Rogers MD				23D. ADDRESS Johns Hopkins Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-9-1970		24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial	
24D. LOCATION Bel Air		24E. (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Rose E. Miller		25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Road 21236	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-420		70 3843		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 3843	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
TELLIS, CARRIE VIOLA				2. DATE AND HOUR OF DEATH APRIL 9, 1970 7:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				MARYLAND		ANNE ARUNDEL 5200	
				C. CITY OR TOWN BALTIMORE MARLEY PARK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 303 COLBY CIRCLE GLEN BURNIE, MD 21061			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07 19 08	9. AGE (In years last birthday) 61	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - SALESLADY		10B. KIND OF BUSINESS OR INDUSTRY KORVETTE STORES		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME WILLIAM HOOD				14. MOTHER'S MAIDEN NAME CARRIE LOWMAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. George J. Tellis 303 Colby Circle 21061 Glen Burnie, Md.		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Uraemic Pericarditis Chr. Glomerulonephritis 2-3 yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MARCH 24 19 70 to APRIL 9 19 70 that (I) (we) lost saw the deceased alive on APRIL 9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Zaheer-Kahn</i>				23B. DATE SIGNED 04 09 70		23C. PHYSICIAN'S NAME (Type) ZAHEER-KAHN	
23D. ADDRESS ST AGNES HOSP BALTO MD 21229		23E. DEGREE		23F. DEGREE		23G. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/70		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. A.A. Co.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR McCully F.H.		25D. ADDRESS 237 Patapsco Ave. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

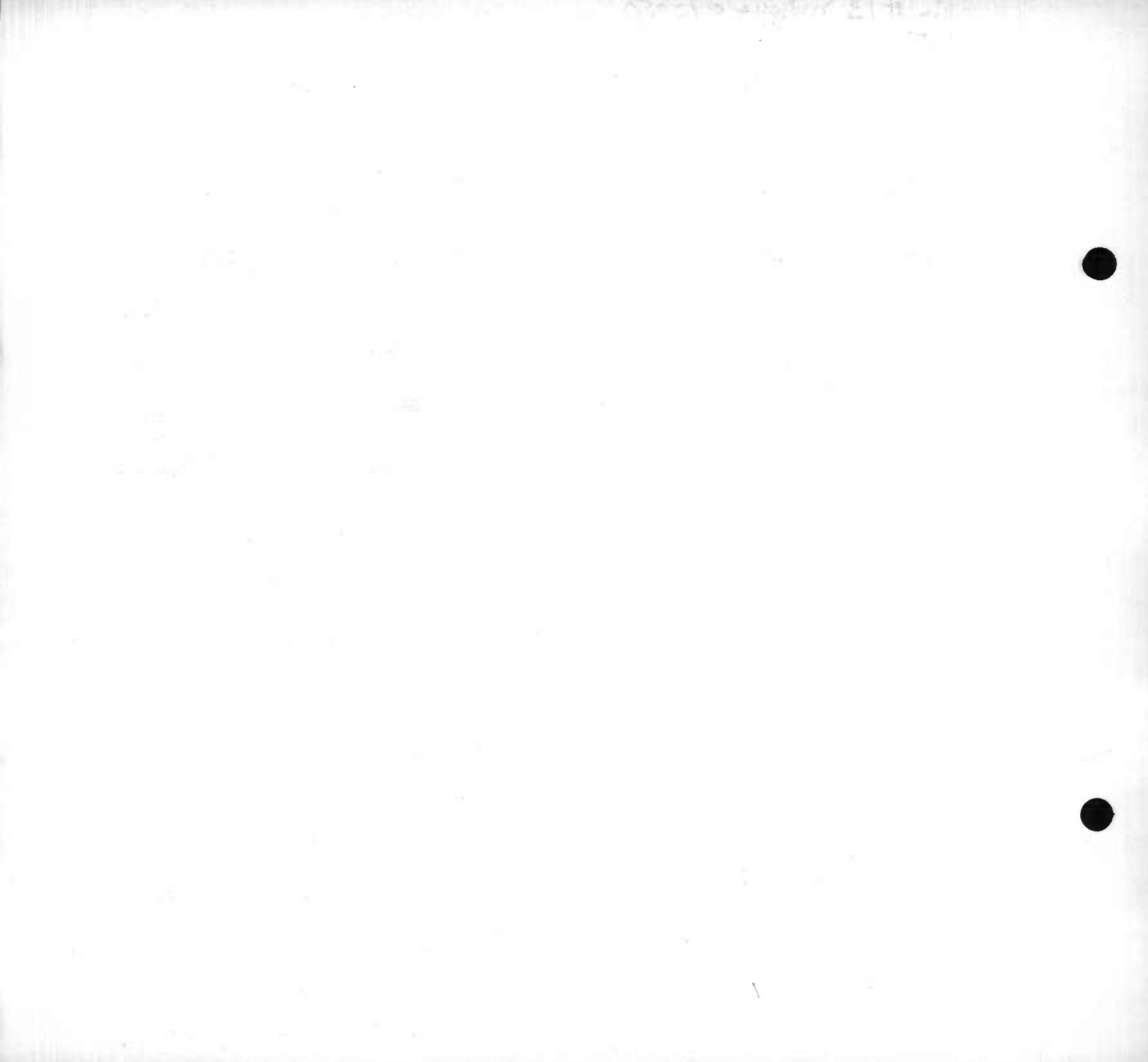
BIRTH NO. <u>S-126 70 3844</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 3844</u>	
1. NAME OF DECEASED (Type or Print) <u>Horace Spicer</u>				2. DATE AND HOUR OF DEATH <u>4/9/70</u> <u>1:12</u> <u>15</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Granada Nursing Home, Inc.</u> <u>90 4017 Liberty Heights Avenue</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>1306</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3515 Kenwick Road</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/26/95</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Hampshire</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Marshall L. Spicer</u>				14. MOTHER'S MAIDEN NAME <u>Florence Pearce</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-10-8759</u>		17. INFORMANT <u>Medical Records - Granada Nursing Home</u>		
18. I <u>1621</u> I <u>I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bronchogenic Carcinoma</u>				<u>1 year</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Emphysema</u>				<u>many years</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11 March</u> 19 <u>70</u> to <u>9 April</u> 19 <u>70</u> and that (II) (we) last saw the deceased alive on <u>9 April</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above <u>(I) (we) (did) (did not) view the body after death.</u>							
23A. SIGNATURE <u>Robert C. Blackman, M.D.</u>				23B. DATE SIGNED <u>9 April 1970</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>Robert C. Blackman, M.D.</u>				23D. ADDRESS <u>Granada Nursing Home</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/13/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1970</u>		25B. NAME OF REGISTRAR <u>Paul E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Ann Donovan - 3818 Roland Ave.</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

in #15 morgue @ 1205P. G-635 70 3845		BALTIMORE CITY HEALTH DEPARTMENT		70 3845
BIRTH NO.		REG. NO.		
1. NAME OF DECEASED (Type or Print) ETHEL M. GARDINER		2. DATE AND HOUR OF DEATH 4/8/70 10⁵⁵ A		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2631		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 4331 Glenmore Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/17/87	9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Mitchell		
14. MOTHER'S MAIDEN NAME Mary Ellen Myers		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-48-0692		17. INFORMANT ADDRESS Mrs. Ethel G. Gauer - 4431 Glenmore Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE RENAL FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 DAYS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GRAM NEGATIVE SEPSIS 6 DAYS		
		(B) DUE TO, OR AS A CONSEQUENCE OF: PERITONITIS 6 DAYS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CARCINOMA OF COLON ? 2 YRS.		
19A. DATE OF OPERATION 4/7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from 4/7 1970 to 4/8 1970 that (1) (we) last saw the deceased alive on 4/8 1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.		
23A. SIGNATURE R. S. Weinberg M.D.		23B. DATE SIGNED 4/8/70		23C. PHYSICIAN'S NAME (Type) ROBERT S. WEINBERG M.D.
23D. ADDRESS The JOHNS HOPKINS Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 4-18		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS John C. Miller Inc-6415 Belair Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

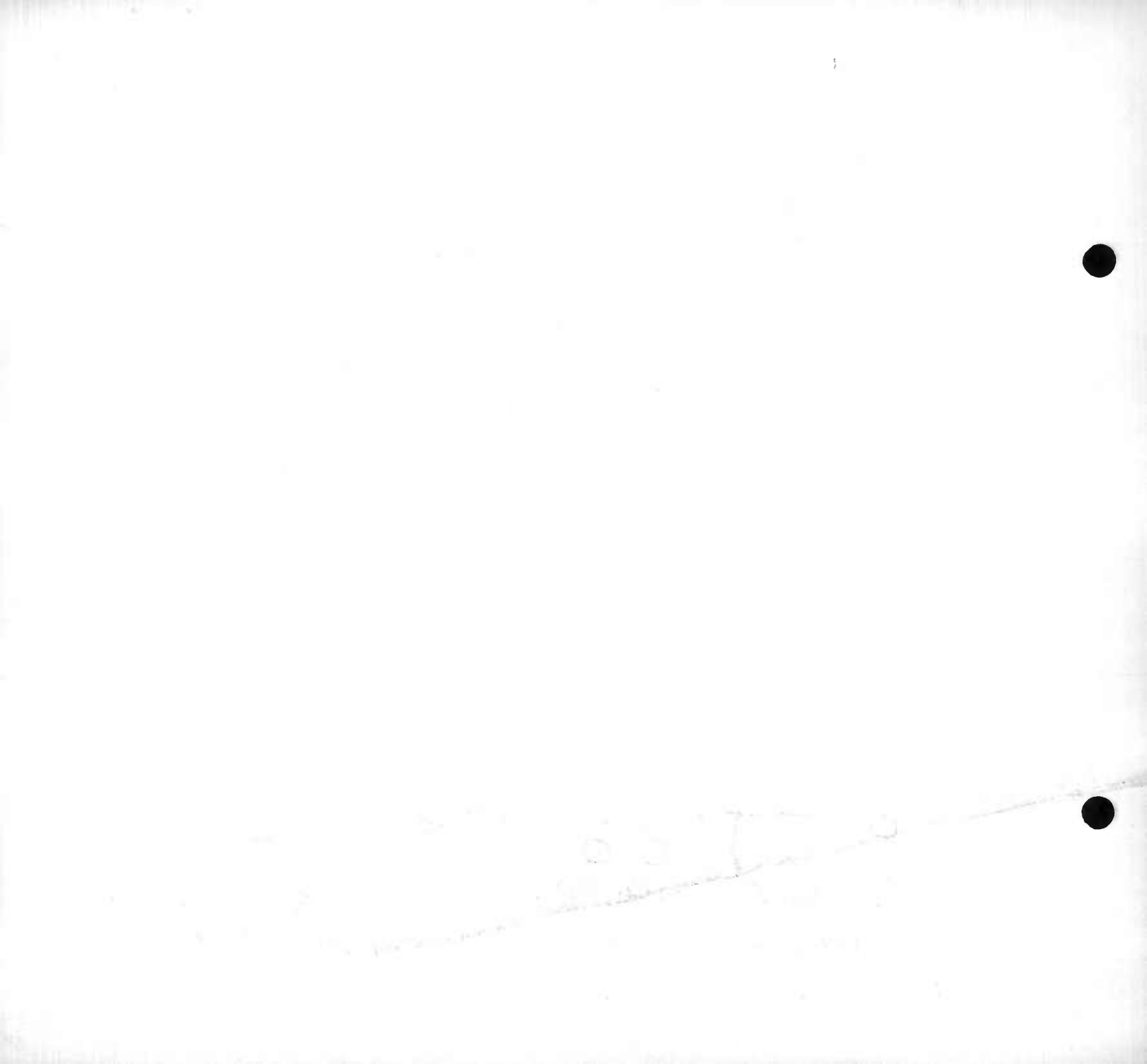
F-654		70 3846		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3846	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) FERNWALT, GLADYS			
2. DATE AND HOUR OF DEATH 4/9/70 1:15 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 26-36				5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1315 Elrino Way 21224				FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 1940 Eastern Avenue Baltimore, Maryland 21224			
8. DATE OF BIRTH 4-20-1891		9. AGE (in years last birthday) 77 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH KING		14. MOTHER'S MAIDEN NAME SARAH HILTON		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 365-18-6338		17. INFORMANT BCH: Records 4940 Eastern Avenue Baltimore, Maryland 21224		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL VASCULAR ACCIDENT ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE ASPIRATION PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days 2 1/2 days	
19. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 4/6 1970 to 4/9 1970 that (H) (we) last saw the deceased alive on 4/9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dennis W. Bleakley MD				23B. DATE SIGNED 4/9/70		23C. PHYSICIAN'S NAME (Type) Dennis W. Bleakley M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 4/13/70		24C. NAME of CEMETERY or CREMATORY OAK LAWN CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.				25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.A.	
25C. FUNERAL DIRECTOR ADDRESS CLERICH FUNERAL HOME, DUNDALK, MD.							

BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH			
CONLEY TETTER				Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 9 70 8:45 p. m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				3. DATE PRONOUNCED DEAD			
FALL ARRESTED BY POLICE AT HOME ADDRESS OR INSTITUTION				Month Day Year Hour April 9, 1970 8:45 p. m.			
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)				A. STATE B. COUNTY			
00 518 S. Hanover St.				Maryland 2201			
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
4/25/1910		59		West Virginia		U.S.A.	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
Walter V. Tetter		Laborer		Ellie Mullenax		No	
17. SOCIAL SECURITY NO.		18. INFORMANT		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		20. DATE OF OPERATION	
235-18-1635		Irene M. Gabbert		Arteriosclerotic cardiovascular disease		21. AUTOPSY? (Yes or No)	
CAUSE OF DEATH		ADDRESS		DUE TO, OR AS A CONSEQUENCE OF:		YES	
(A) IMMEDIATE CAUSE		-624 N. Streeper St		Aspiration pneumonia			
DUE TO, OR AS A CONSEQUENCE OF:				(B) alcoholic intoxication			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) _____			
(C) _____				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
				Aspiration pneumonia			
				Arteriosclerotic cardiovascular disease, severe			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				DATE SIGNED			
Isidore Mihalakis, M.D.				4/10/70			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Removal		4/10/70		Arbovale Cemetery		Pocahontas Co., W. Va.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 13 1970		Robert E. Taylor, M.D.		Robert C. Altenburg Funeral Home Inc		6009 Harford Rd. - Balto., Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3848	
B-236 70 3848 BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) William R. Beckett			2. DATE AND HOUR OF DEATH 4/10/70 2:00P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1803 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 875 W. Lombard		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/14/90	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10B. KIND OF BUSINESS OR INDUSTRY Self Employed		
11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Mollie Berger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.I			16. SOCIAL SECURITY NO. 219-30-9300		
17. INFORMANT Gladys Beckett			ADDRESS (wife)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Mid brain hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4/3/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/6 19 70 to 4/10 19 70 that (I) (we) last saw the deceased alive on 4/10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen L. Winter MD			23B. DATE SIGNED 4/10/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) STEPHEN L. WINTER			23D. ADDRESS Univ. of Md. Hosp		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/70		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 13 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR John J. Gowan & Son Inc.			
25D. ADDRESS 901 Hollins St. 23, Md.					

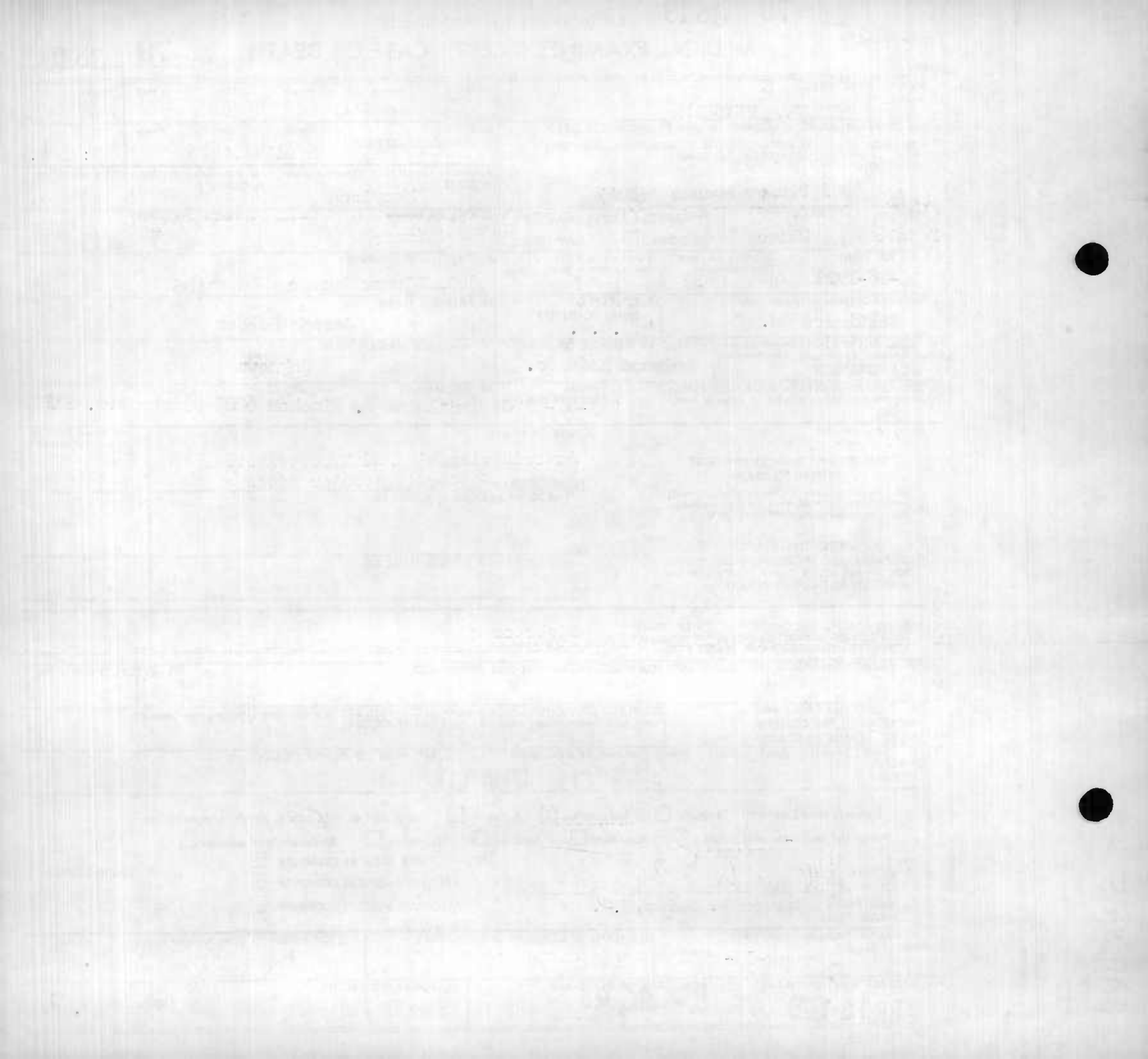


BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **70 3849**

1. NAME OF DECEASED E (Type or Print) STELLA FINCHAM		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. PRONOUNCED DEAD Month Day Year Hour April 7, 1970 5:25 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6005 Plumer Avenue (DOA)		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 2631	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10-28-1911	10. AGE (In years last birthday) 58 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Belcer	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		14B. KIND OF BUSINESS OR INDUSTRY Redwood Rain Co.	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 215-01-4120		18. INFORMANT ADDRESS Geraldine E. Fincham 6005 Plumer Ave. 21206	
19. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. </div> <div style="width: 45%;"> Arteriosclerotic and Hypertensive (A) IMMEDIATE CAUSE Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div>			
20. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/7/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-10-1970	
24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore City Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Rd. 21236			



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W-000

70 3850

BALTIMORE CITY HEALTH DEPARTMENT

X

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

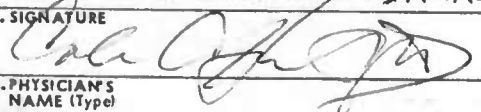
REG. NO. 70 3850

1. NAME OF DECEASED (Type or Print) TOMMY WAYE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> March 21, 1970 Hour 10:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year March 21, 1970 Hour 10:45 P. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 5300		C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6/27/49		10. AGE (In years lost birthday) 20 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Waye		14. MOTHER'S MAIDEN NAME Mabel Nobel	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT Rosewood Records		ADDRESS Owings Mills, Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Craniocerebral Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hydrocephalus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rosewood State Hospital		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 2-26-70 UNK. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Unknown how injury occurred	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/22/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 10, 70	
24C. NAME OF CEMETERY or CREMATORY Rosewood Cemetery		24D. LOCATION (City, town, or county) (State) Owings Mills, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Ronald N. Kornblum, M.D.	
25C. FUNERAL DIRECTOR J. F. Eline & Sons		ADDRESS Reisterstown, Md	

ACADEMICALLY PROFICIENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-565 70 3851		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3851	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CATHERINE F. AMRHEIN			2. DATE AND HOUR OF DEATH 4/10/70 2:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2102		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1229 W. Cross Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-16-86	9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY United States		13. FATHER'S NAME Kneise		14. MOTHER'S MAIDEN NAME Anna ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-20-3804-A		17. INFORMANT Edna Anna Moore - 1229 W. Cross St.	
18. 151.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ASTRIC CARCINOMA (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS		
19A. DATE OF OPERATION 9		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 28 1970 to APRIL 10 1970 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 10 1970 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 4/10/70	
23C. PHYSICIAN'S NAME (Type) Dr. C. C. Johnson				23D. ADDRESS South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/70		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.		25A. DATE RECD. BY HEALTH DEPT. APR 13 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR John F. Corcoran & Son, Inc.		25D. ADDRESS 901 E. Holliston St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

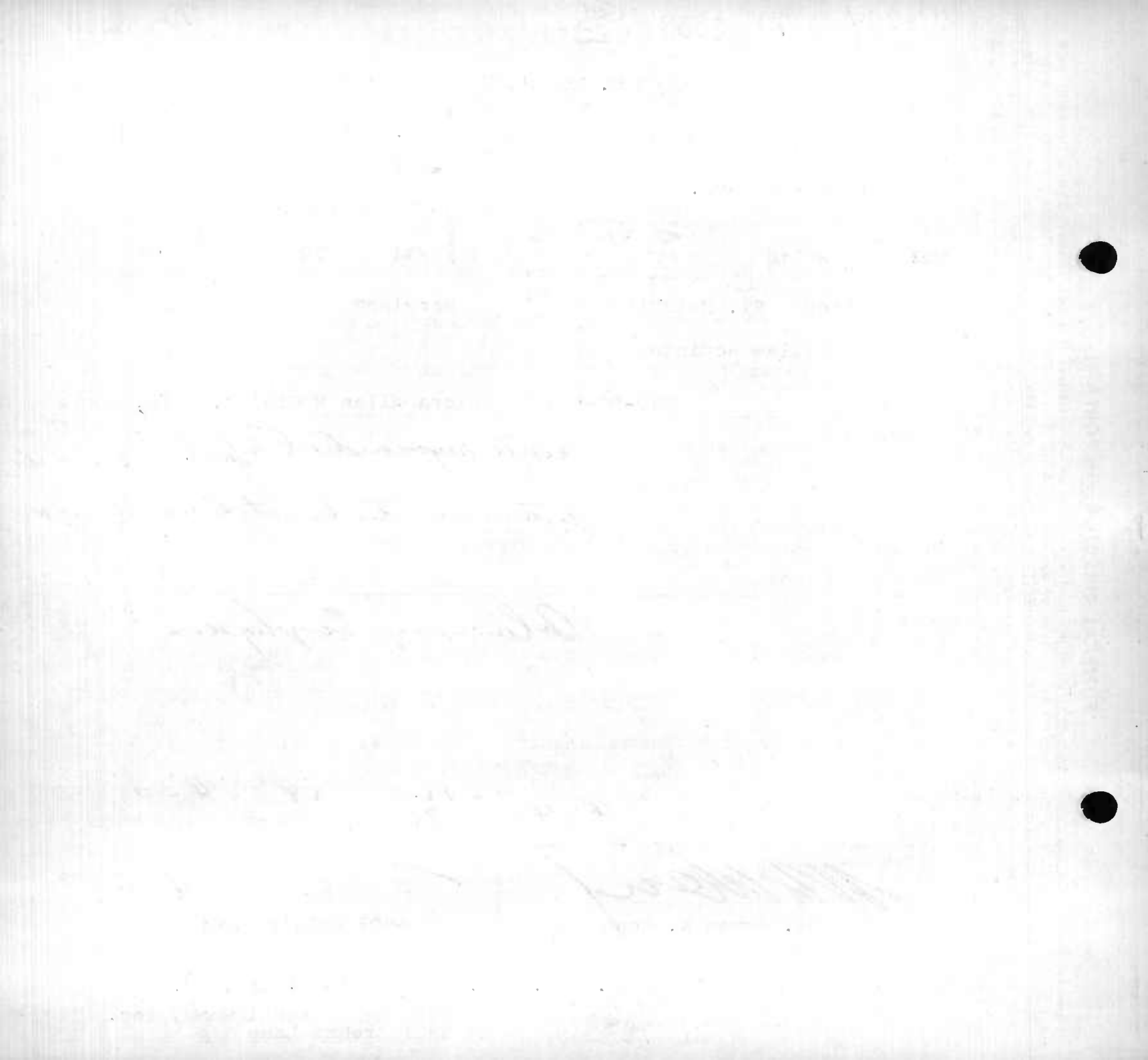
Baltimore City Health Department				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3852	
T-162 70 3852		BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				JOSEPHINE TABORSKY		April 7, 1970 12:50 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE B. COUNTY			
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md. Balto. 5308			
90 House in the Pines (Belvedere)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				House in the Pines			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5/9/77	92			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		at home		Czechoslovakia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Frank Matousek				Barbara Miller			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		216-07-01370		Emil Taborsky, son, 708 Saylor Court 21204			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Sep. 19 61 to April 7, 19 70, that (I) (we) lost saw the deceased alive on April 7, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Bernard J. Cohen				4/8/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Bernard J. Cohen				Marylander Apt.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/10/70		Bohemian National Cem.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 13 1970		Robert E. Taborsky		Schimunek Funeral Home, Inc.		3331 Brehms Lane	

6714 Queens Ferry Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

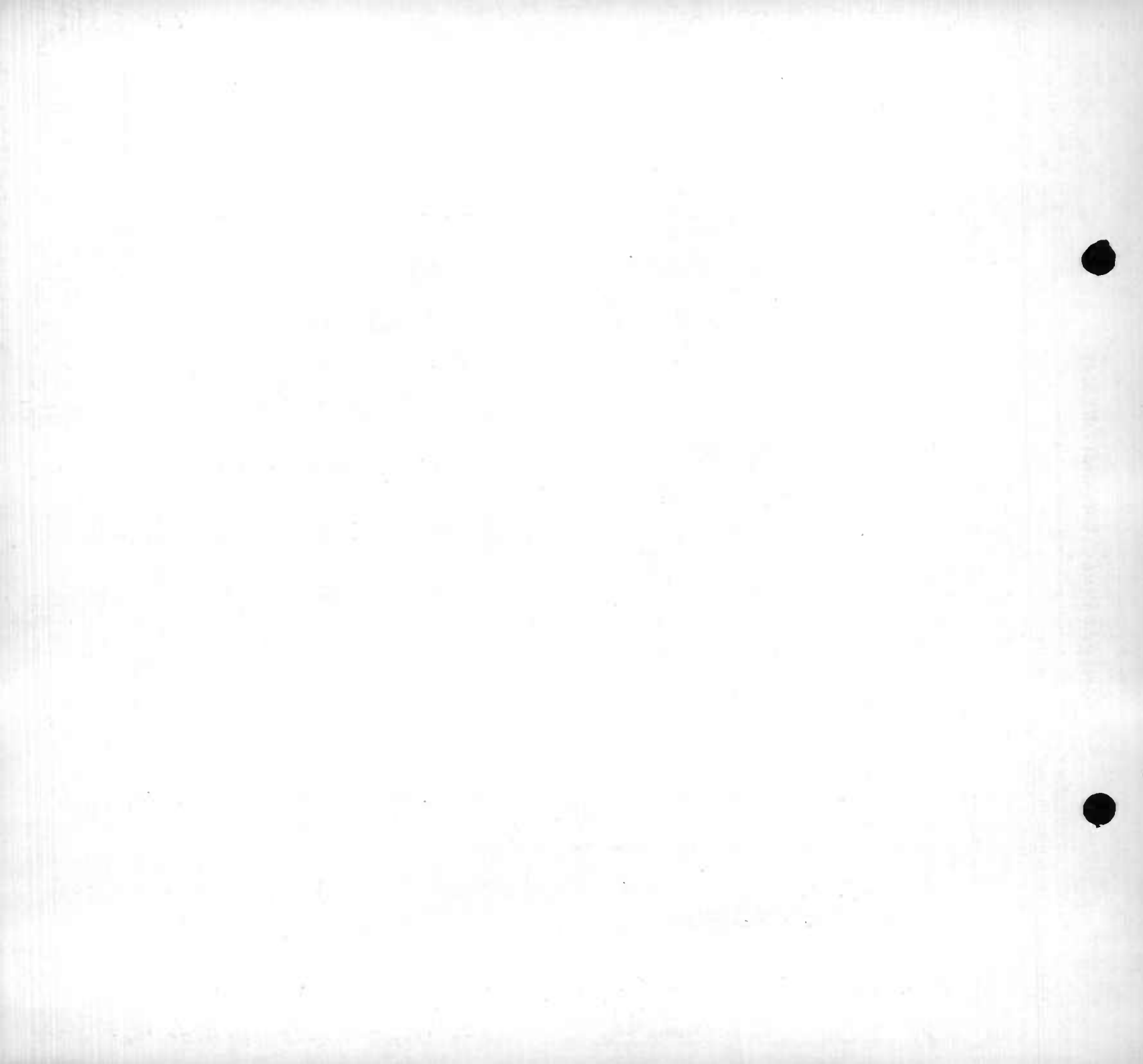
<div style="display: flex; justify-content: space-between;"> M-254 70 3853 </div> <div style="display: flex; justify-content: space-between;"> BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 70 3853 </div>			
BIRTH NO. 1 1. NAME OF DECEASED (Type or Print) WILLIAM D. MCGINLEY		2. DATE AND HOUR OF DEATH 4/7/70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4907 Orville Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md., B. COUNTY 21205 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4907 Orville Avenue	
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/94 9. AGE (In years last birthday) 75 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Ft. Holabird		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William McGinley		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-8639A	17. INFORMANT ADDRESS Laura Allan McGinley, wife, above
1B. 4/10/9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic heart disease (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years 20 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. CAUSE OF DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-12-1958 to 4-7-1970 , that (I) (we) last saw the deceased alive on 4-4-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED 4-9-70	
23C. PHYSICIAN'S NAME (Type) Dr. Wyman K. Wong		23D. ADDRESS 6801 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/10/70	24C. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

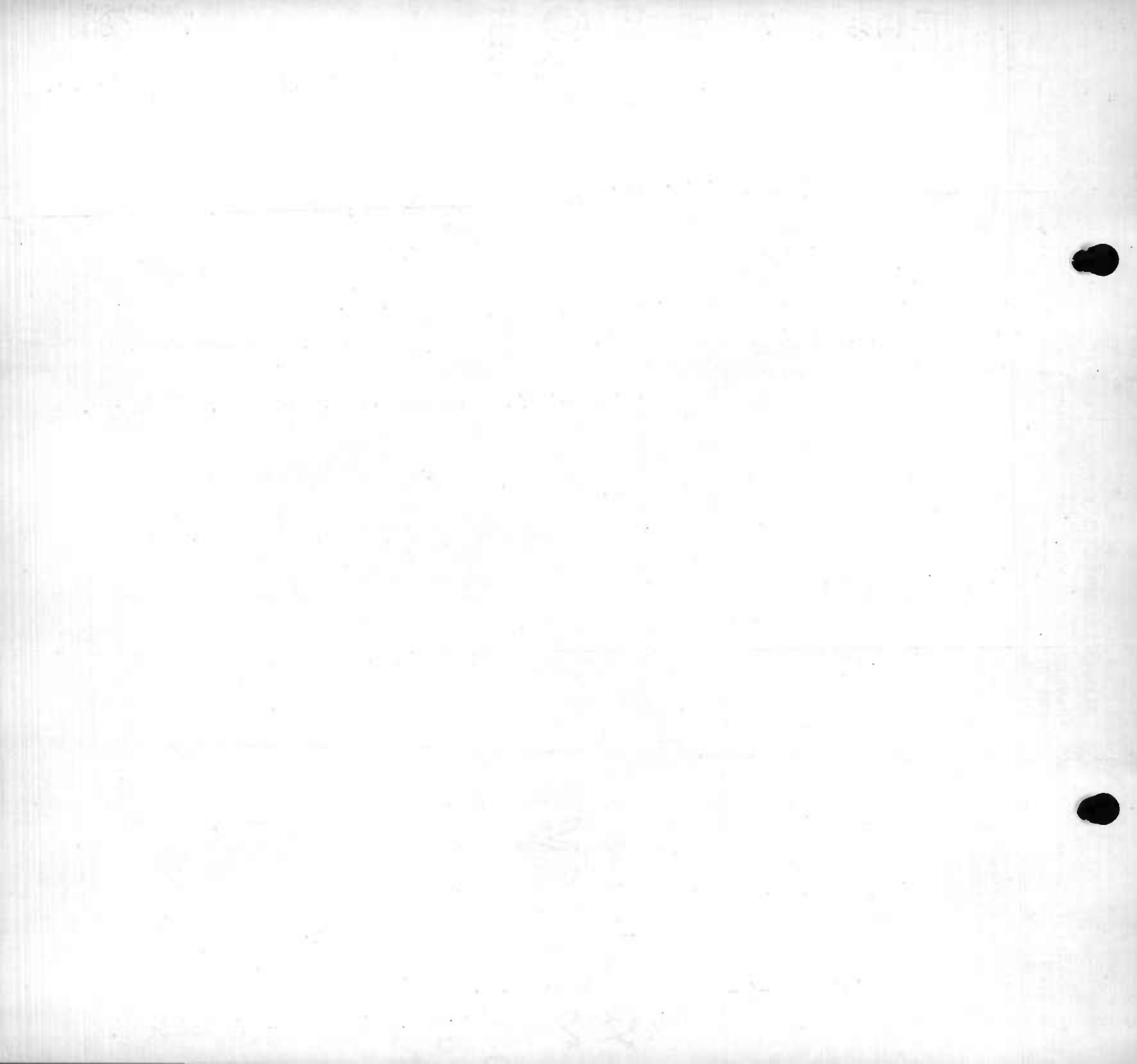
S-630 70 3854		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3854	
1. NAME OF DECEASED (Type or Print) Mattie Sherrod		2. DATE AND HOUR OF DEATH 4-10-70 3:30 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 2002			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Crawford Nursing Home 2117 Denison St.		C. CITY OR TOWN Ba l to.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2727 W. Fairmount Ave			
5. SEX F	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-1893	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. C.	
13. FATHER'S NAME un Known		14. MOTHER'S MAIDEN NAME Anna Bell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Wm H. Sherrod ADDRESS 2727 Fairmount	
18. 433.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral arteriosclerosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis (B) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 2, 1970 to April 10, 1970 , that (I) (we) last saw the deceased alive on April 9, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) did not view the body after death.					
23A. SIGNATURE Abraham B. Hurwitz M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED April 13, 1970	
23C. PHYSICIAN'S NAME (Type) ABRAHAM B. HURWITZ, MD.		23D. ADDRESS 7501 Liberty Rd, Beltsville, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-13-70	24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.		24D. LOCATION (City, town, or county) (State) A. A. Co Md	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970	25B. NAME OF REGISTRAR Robert E. Farber M.D.	25C. FUNERAL DIRECTOR 1011-13 Sullivan Funeral Home - N. Arlington Ave		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

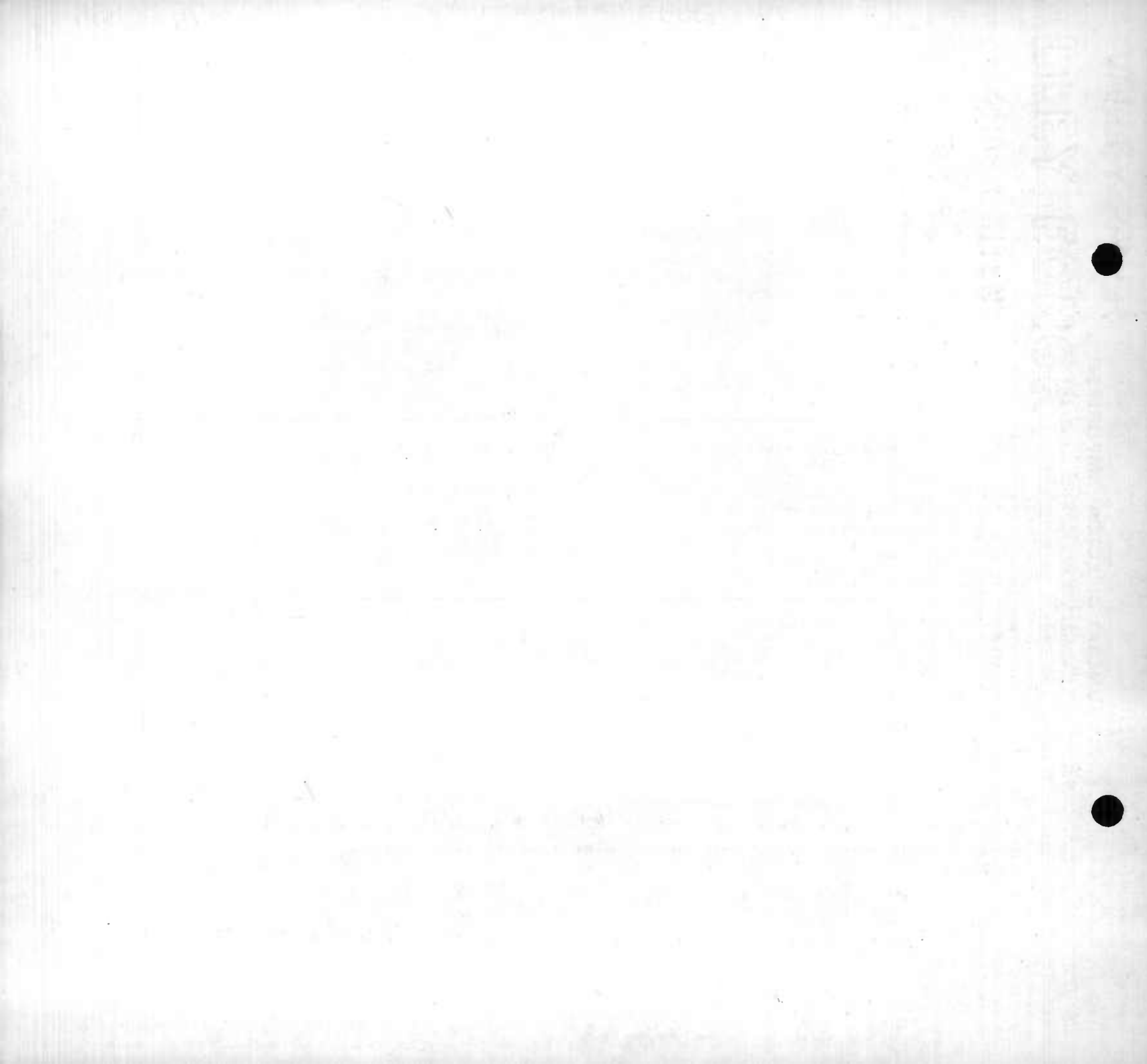
Baltimore City Health Department				REG. NO. 70 3855	
T-616 70 3855 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Frank A. Trabert		2. DATE AND HOUR OF DEATH April 6, 1970 6:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1404 N. Milton Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 833 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1404 N. Milton Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 21, 1916	9. AGE (In years lost birthday) 53
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10B. KIND OF BUSINESS OR INDUSTRY Wolf-Mann		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Philip Trabert		14. MOTHER'S MAIDEN NAME Margaret Reinsfelder			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-1081		17. INFORMANT Margaret Trabert ADDRESS -1404 N. Milton Ave.	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE Acute Coronary DUE TO, OR AS A CONSEQUENCE OF: Arterio Vascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Edema Legs (C) </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April - 1 - 19 70 to April - 6 - 19 70, that (I) (we) last saw the deceased alive on April - 6 - 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE William G. Geyer M.D.		23B. DATE SIGNED April - 7 - 70		23C. PHYSICIAN'S NAME (Type) WILLIAM G. GEYER M.D.	
23D. ADDRESS 1564 N. Milton Ave.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-10-70		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR John C. Miller		25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3856	
C-452		70 3856		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>COLLINS WILLIAM</i>		2. DATE AND HOUR OF DEATH <i>4-10-1970</i> 11:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALLOU ST. BALTO.</i>		C. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION <i>LAKE DRIVE NURSING HOME</i> <i>2401 EUTAW PLACE</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>MALE</i>		6. RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <i>7-8-1893</i>		9. AGE (In years last birthday) <i>86</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>UNKNOWN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>UNKNOWN</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND BALTIMORE</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>213-01-5762</i>		17. INFORMANT <i>UNKNOWN</i>	
18. <i>412.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>CARDIAC ARREST</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>ASCVD + CHF.</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD + CHF.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>JAN 16 1970</i> to <i>APRIL 10 1970</i> , that (I) (we) last saw the deceased alive on <i>APRIL 8 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Wm. A. ...</i>		23B. DATE SIGNED <i>4/10/70</i>		23C. PHYSICIAN'S NAME (Type) <i>DR. F. ... MD</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. F. ... MD</i>		23D. ADDRESS <i>7935 ...</i>		23E. DEGREE <i>MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>4/11/70</i>		24C. NAME of CEMETERY or CREMATORY <i>Wm. A. ...</i>	
24C. NAME of CEMETERY or CREMATORY <i>Wm. A. ...</i>		24D. LOCATION (City, town, or county) (State) <i>Balt Md</i>		24E. DATE REC'D BY HEALTH DEPT. <i>APR 13 1970</i>	
24E. DATE REC'D BY HEALTH DEPT. <i>APR 13 1970</i>		24F. NAME OF REGISTRAR <i>...</i>		24G. FUNERAL DIRECTOR <i>...</i>	
24G. FUNERAL DIRECTOR <i>...</i>		24H. ADDRESS <i>...</i>		24I. SIGNATURE <i>...</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

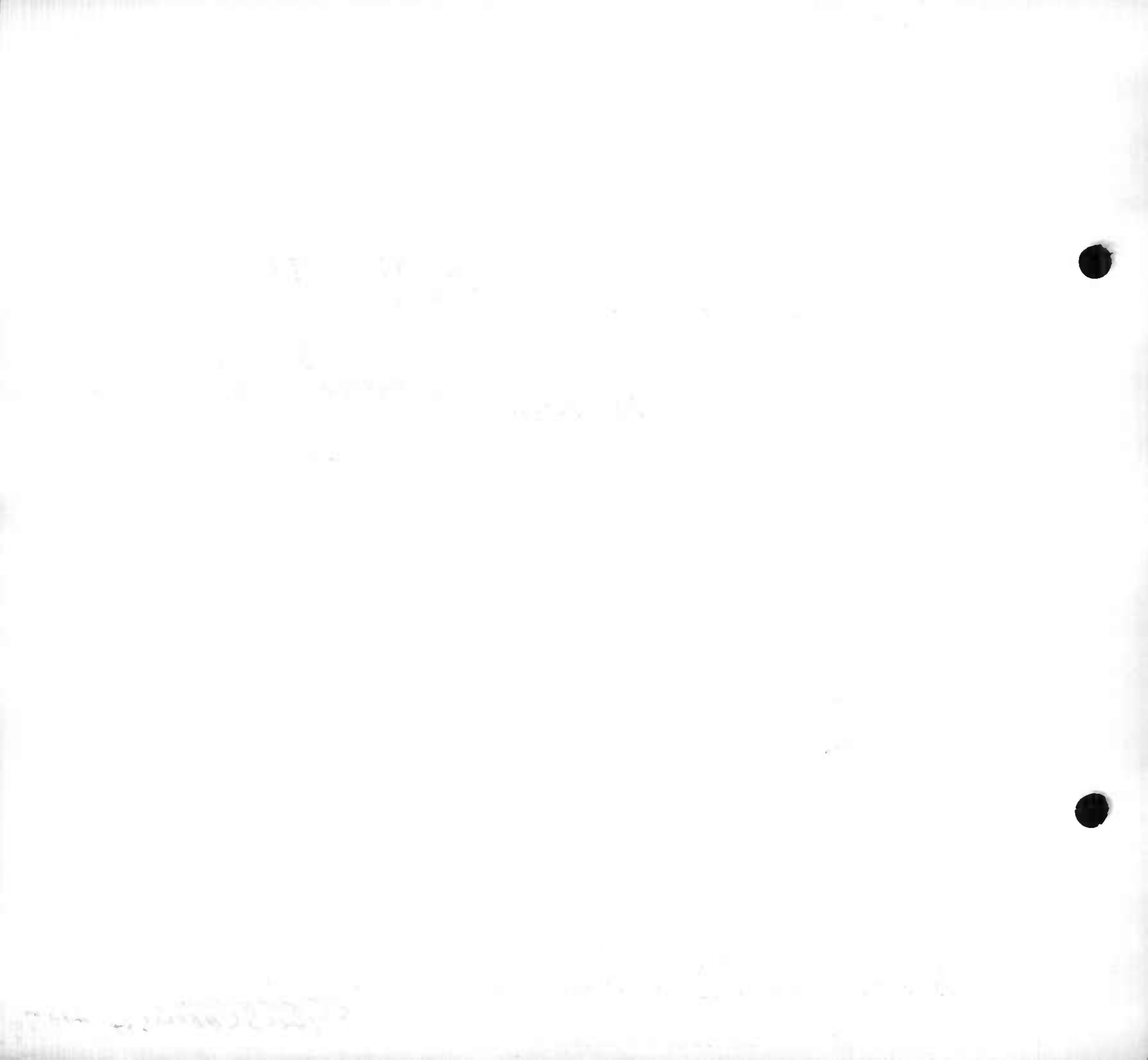
T-512		70 3857		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3857	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Rudolph Desales Thompson</u>				2. DATE AND HOUR OF DEATH <u>April 8, 1970 9:15 pm</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hosp.</u>				A. STATE <u>MD.</u> B. COUNTY <u>Baltimore City</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>12/28/12</u> 9. AGE (in years last birthday) <u>57</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigerator Mechanic</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
11. BIRTHPLACE (State or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Francis Xavier Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Edith G. Gwynne</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes. Mar. 27, 1942 to Dec 19, 45</u>				16. SOCIAL SECURITY NO. <u>578-03-5303</u>			
17. INFORMANT <u>Mrs. Helen Thompson (wife)</u>				ADDRESS <u>1218 N. Charles St. Baltimore 21201</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>162.1 I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH <u>162.1 I</u> <u>Branchogenic carcinoma</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>7</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <u>Yes</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR			
22. I certify that (I) (this hospital) attended the deceased from <u>April 7, 1970</u> to <u>April 8, 1970</u> that (I) (we) last saw the deceased alive on <u>April 8, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Hubert T. Gurley, MD</u>				23B. DATE SIGNED <u>April 8, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>Hubert T. Gurley</u>				23D. ADDRESS <u>University Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>Apr. 13, 1970</u>			
24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park National Cem.</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>			
25C. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u>				ADDRESS <u>Baltimore Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 3858	
BIRTH NO. A-516 70 3858		1. NAME OF DECEASED (Type or Print) MARY L. AMBROSE			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION South Baltimore Memorial Hospital		2. DATE AND HOUR OF DEATH 4-9-70 11:20 A.M. 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2301 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1420 S. CHARLES ST. # 30 21230			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-97	9. AGE (In years last birthday) 72 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY AT Home		11. BIRTHPLACE (State or foreign country) BRUNSWICK MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES PHILLIPS			14. MOTHER'S MAIDEN NAME RUBY Simmons		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 105-02-7867		17. INFORMANT Daughter FRANK P. BURY 3714 AQUIN LRD - 21235 8 LEVAM W. (son) - SAME	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Terminal Bunchopneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF: (C) _____ Diabetes Mellitus, uncontrolled </div> </div>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indotify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-27- 19 70 to 4-9 19 70 that (I) (we) last saw the deceased alive on 4-9- 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Virginia Y. Faust, M.D.				23B. DATE SIGNED 4-9-70	
23C. PHYSICIAN'S NAME (Type) VIRGINIA Y. FAUST, M.D.				23D. ADDRESS South Baltimore Memorial Hospital	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE APR. 13-70		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	
24D. LOCATION (City, town, or county) (State) Glen Burnie Co. Md		25A. DATE REC'D BY HEALTH DEPT. APR 13 1970			
25B. NAME OF REGISTRAR Ruth E. Evans		25C. FUNERAL DIRECTOR CURTIS E. EVANS			
25D. ADDRESS 1400 S. CHARLES ST. 21230					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3859	
<p>J-525 70 3859</p> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) Lottie Johnson</p>		<p>2. DATE AND HOUR OF DEATH 4/8/70 9:00 P.M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Century Home</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1703</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 701 W. Lanvale St.</p>			
<p>5. SEX F</p>	<p>6. RACE N</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 10/07/91</p>	<p>9. AGE (In years lost birthday) 78</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H W</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) South Carolina</p>	
<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>		<p>13. FATHER'S NAME George Hamlen</p>			
<p>14. MOTHER'S MAIDEN NAME Ella</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>			
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Veneita Bayer ADDRESS 701 W. Lanvale St.</p>			
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 250.9 I</p>		<p>CAUSE OF DEATH (A) IMMEDIATE CAUSE Cardio-Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure (B) Arteriosclerosis CVD DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes Mellitus</p>			
<p>19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from March 26/70 to April 8 1970, that (I) (we) last saw the deceased alive on April 8 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did not) view the body after death.</p>					
<p>23A. SIGNATURE William D Applefezt</p>				<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) William D Applefezt</p>				<p>23D. ADDRESS 6615 Reisterstown Rd</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 4-13-70</p>		<p>24C. NAME OF CEMETERY or CREMATORY Mt. Auburn</p>	
<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>		<p>25A. DATE REC'D BY HEALTH DEPT. APR 13 1970 25B. NAME OF REGISTRAR Robert E. Taylor R.D.</p>			
<p>25C. FUNERAL DIRECTOR CHARLES A. Rice ADDRESS 661 W. BARRE ST.</p>				<p>25D. DATE</p>	

Charles the Great
King of the West Saxons
Died at Winchester, (A.D.)
Died at Winchester

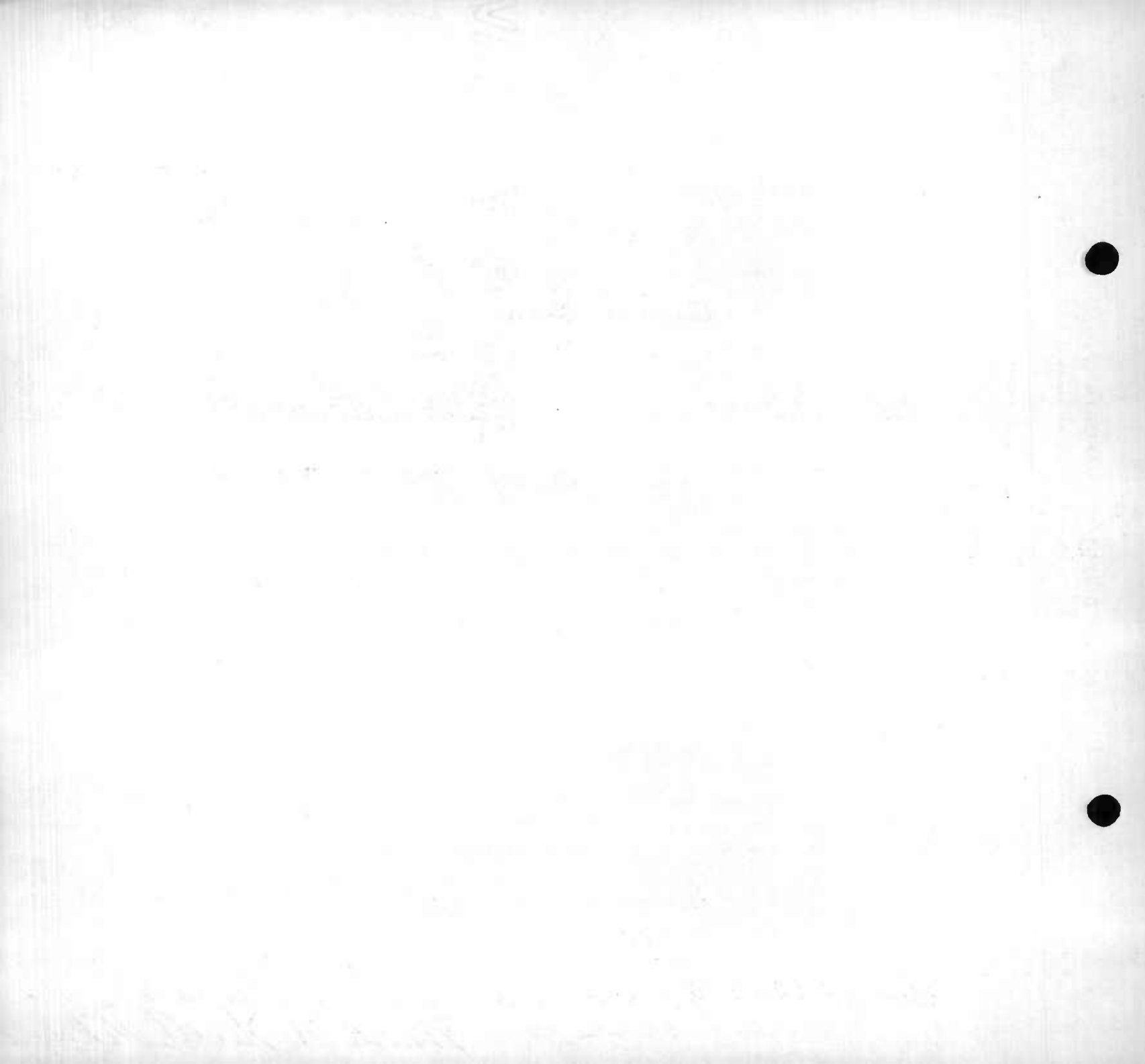
April 8 750
Died at Winchester

William the Conqueror
Died at Winchester
April 8 750
Died at Winchester

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3860				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3860	
1. NAME OF DECEASED (Type or Print) William A Davis Jr.				2. DATE AND HOUR OF DEATH 4-9-70 11:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 5300 C. CITY OR TOWN Baltimore 8 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1008 Kingston Rd.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-05-06		9. AGE (In years lost birthday) 63		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10B. KIND OF BUSINESS OR INDUSTRY Pharmaceutical Sales		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? American				13. FATHER'S NAME William A. Davis Sr.			
14. MOTHER'S MAIDEN NAME Maria K. Withenill				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None			
16. SOCIAL SECURITY NO. 213-14-0283				17. INFORMANT Mrs. Catherine H. Woods 1008 Kingston Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) I 347.9 CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Brain damage (anoxic) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Gastric Ulcer				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-25-70 to 4-9-70, that (I) (we) last saw the deceased alive on 4-9-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] DEGREE				23B. DATE SIGNED 4-9-70		23C. PHYSICIAN'S NAME (Type) WERNER MEIER MD	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				70 3861		REG. NO.	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) ORMAN J. SCOTT		2. DATE AND HOUR OF DEATH April 9, 1970 12:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME ? Hosp.				A. STATE MARYLAND		B. COUNTY 2401	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1410 REYNOLDS ST.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-25-09	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water proofer			10B. KIND OF BUSINESS OR INDUSTRY SELF Employed			11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME DAVID SCOTT				
14. MOTHER'S MAIDEN NAME McCarthy			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				
16. SOCIAL SECURITY NO. 17510 6300			17. INFORMANT FRANCES SCOTT				
ADDRESS SAME							
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) UREMIA, pericardial effusion							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). MALIGNANCY, LUNGS							
19A. DATE OF OPERATION 3-8-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERICARDIAL EFFUSION		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 1, 1970 to April 9, 1970 that (I) (we) last saw the deceased alive on April 9, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Corazon Vergara, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-9-70	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D.				23D. ADDRESS Church Home Hosp. Balt., Md. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/70		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		24D. LOCATION Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc., 1501 E. Fort Avenue			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3862	
A-652 70 3862 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lucy E. Ahrens		2. DATE AND HOUR OF DEATH April 11, 1970 8⁵⁰ P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 902		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 4051 The Alameda		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1884	9. AGE (in years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME Frederick W. Courtice		14. MOTHER'S MAIDEN NAME Emma Frances Norbeck	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-2270 D		17. INFORMANT Mr. C. E. Dunham	
				ADDRESS 4051 The Alameda	
18. 250.9 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerotic coronary atherosclerotic disease					
(B) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF: 2 y.					
(C) _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 19 68 to Feb. 20 19 70 that (I) (we) last saw the deceased alive on Feb. 20 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 4-13-70	
23C. PHYSICIAN'S NAME (Type) Dr. Carlos E. Aranaga				23D. ADDRESS 1701 Meridene Drive	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-70		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Woodlawn, Balto., Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Jarber, M.D.		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.	
				ADDRESS 4905 York Road Balto., Md. 21212	

NO 3885

H-229 NO 3885

FUNERAL DIRECTOR: IMPORTANT

Certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> D-520 70 3863 </div>		BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH		REG. NO. 70 3863	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) MRS. DOROTHY E. DIMMICK		2. DATE AND HOUR OF DEATH APRIL 10, 1970 11⁰⁵ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Hillcrest Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New York B. COUNTY V-29 C. CITY OR TOWN Long Island D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Port Washington			
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/1887 9. AGE (In years last birthday) 83-81		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles F. Escher	
14. MOTHER'S MAIDEN NAME Louise Dungan		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 117-36-0637	
17. INFORMANT A Mrs. Natalie Laubach		ADDRESS 3838 Roland Ave			
18. 403X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Nephrosclerosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Nephrosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years +	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertensive Cerebro-Vascular Disease (with sensitivity)		19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20 years	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from OCT. 26 1969 to APRIL 10 1970 , that (I) (we) last saw the deceased alive on APRIL 10 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert W. Garis, M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED APRIL 10, 1970	
23C. PHYSICIAN'S NAME (Type) ROBERT W. GARIS, M.D.		23D. ADDRESS 12 E. EAGER ST., BALTIMORE, MD. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial		24B. DATE 4/14/70		24C. NAME OF CEMETERY or CREMATORY Hillsdale Cem.	
24D. LOCATION (City, town, or county) (State) Hillsdale, New York		25A. DATE REC'D BY HEALTH DEPT. APR 18 1970			
25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd Balto., Md. 21212			

4/24/70 - Case then sent from funeral director.
Bc.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

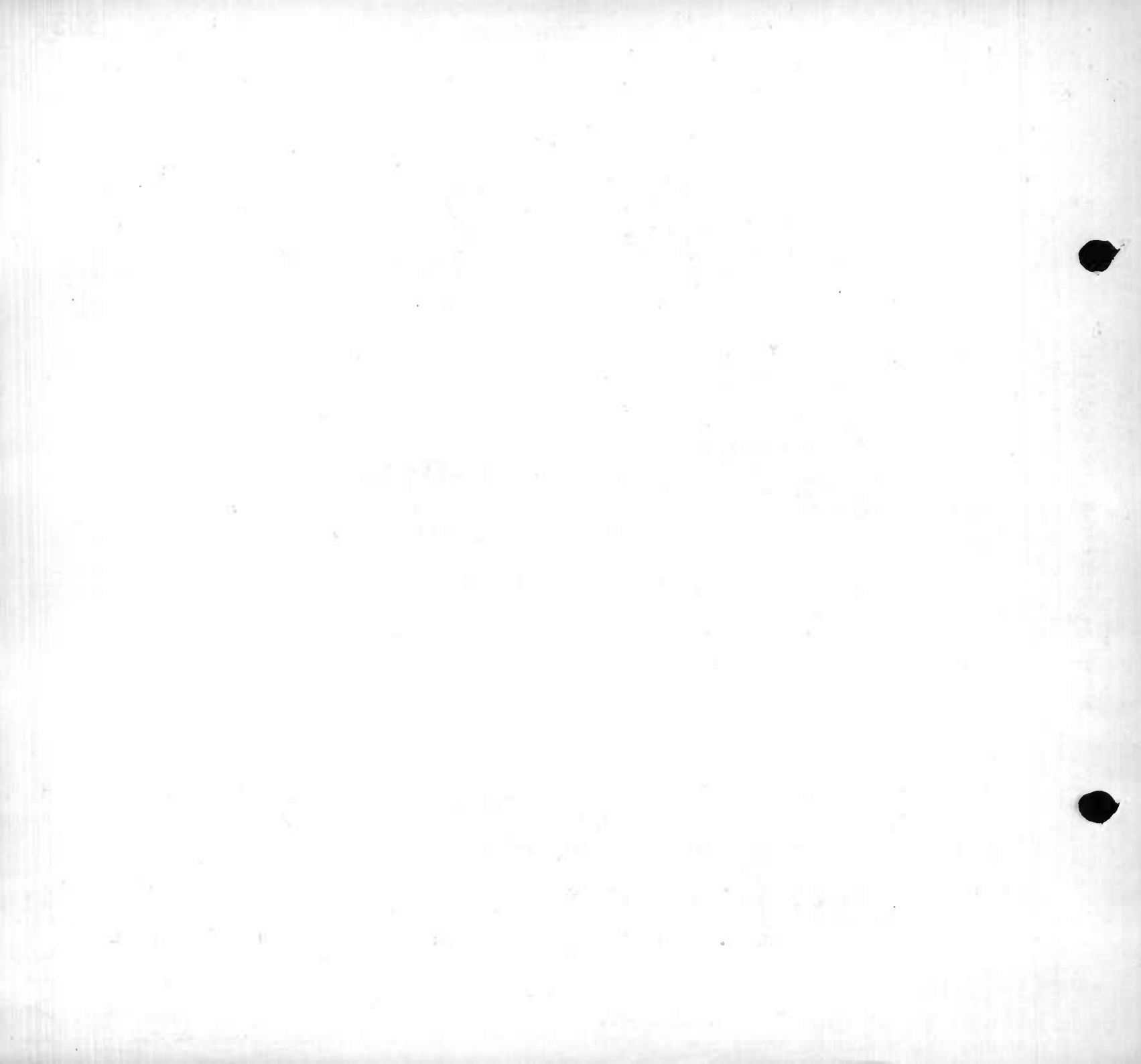
<div style="display: flex; justify-content: space-between;"> F-636 70 3864 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		70 3864 REG. NO.	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) GEORGE WALTER FREDERICK		2. DATE AND HOUR OF DEATH 4/12/70 10²⁵ P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1202 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 201 E. UNIVERSITY PARKWAY			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/92	9. AGE (in years last birthday) 77	10. UNDER 1 Yr. Months 1 Days 25 Hours 0 Min. 0
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE BROKER		10B. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME M. MARTIN FREDERICK			14. MOTHER'S MAIDEN NAME ROSA. BUSHMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 213-01-2266		17. INFORMANT MRS. ANNA M. FREDERICK	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 436.91		CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory failure DUE TO, OR AS A CONSEQUENCE OF: (B) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (C) C. V. A.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hours 14 days 17 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/27 1970 to 4/12 1970 that (I) (we) last saw the deceased alive on 4/12 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anne L. Leddy M.D.				23B. DATE SIGNED 4/12/70	
23C. PHYSICIAN'S NAME (Type) Dr. Anne L. Leddy		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-70		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 13 1970			
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins Sons Co.			
25D. ADDRESS Baltimore, Md.		25E. ADDRESS 4905 York Rd. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3865	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) CORA JONES		2. DATE AND HOUR OF DEATH 9 APRIL 1970 11¹⁵ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2004 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2068 Hollins St			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/16	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hoke Co. N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME LEO MC GRAY			
14. MOTHER'S MAIDEN NAME Goldie Jones		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 231-30-0205		17. INFORMANT Mollie Jones		ADDRESS Same	
18. CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 10 YEARS	
(A) IMMEDIATE CAUSE UREMIA DUE TO, OR AS A CONSEQUENCE OF:					
(B) CHRONIC PYELONEPHRITIS DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/5 19 70 to 4/9 19 70 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/9 19 70 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Karl J. Kramer M.D.				23B. DATE SIGNED 9 APRIL 1970	
23C. PHYSICIAN'S NAME (Type) KARL J. KRAMER		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-70		24C. NAME OF CEMETERY or CREMATORY Mountain Grove Cem.	
24D. LOCATION (City, town, or county) (State) Racford N. Carolina					
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Ed. B. ...		25C. FUNERAL DIRECTOR Ed. B. ...	
				ADDRESS Racford, N.C.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		70 3866		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3866	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
				WILLIAM JONES				04-09-70 2:50 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY				1002	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
33 THE JOHNS HOPKINS HOSPITAL				BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER				711 STIRLING STREET	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9-9-12		57	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				None		Baltimore, Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
				Candace Swift					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes				217-09-7180		Shirley Jones		Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.1				Cardiorespiratory arrest					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
				HASCVD, Coronary art disease					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				COPD					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (1) (this hospital) attended the deceased from April 4, 1969 to 4/9, 1970 that (2) (we) last saw the deceased alive on Jan 19, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
David B. Case, M.D.				4/9/70					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
DAVID B. CASE				THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		4-14-70		Mt. Auburn Cemetery		Baltimore		Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 13 1970		Ruth E. Taylor, R.D.		Shirley Jones		1002 Stirling St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3867	
1. NAME OF DECEASED (Type or Print) MOORE, WILLIAM H		2. DATE AND HOUR OF DEATH 04-08-70 7:35P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPIT.		A. STATE MD.		B. COUNTY BALTO	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3322 VIRGINIA AVE.					
5. SEX MALE	6. RACE BLACK	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-23-17	9. AGE (in years last birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Gives kind of work done during most of working life, even if retired) WORKER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN			
14. MOTHER'S MAIDEN NAME UNKNOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN YES			
16. SOCIAL SECURITY NO. 217-26-2310		17. INFORMANT Maggie Moore			
18. 4-3-70 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Intra-cerebral hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/8 19 70 to 4/9 19 70 that (I) (we) last saw the deceased alive on 4/8 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. P. Mikew				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) J. P. MIKOW				23D. ADDRESS UMH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-70		24C. NAME of CEMETERY or CREMATORY Baltimore Cat	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. APR 13 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR E. O. Wilson			
25D. ADDRESS 1000 Brantley Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 8-626 70 3868 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 70 3868	
BIRTH NO. KSAVERA BRAGER		1. NAME OF DECEASED (Type or Print) Sophie Brager	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Balt. Genl. Hosp 43		2. DATE AND HOUR OF DEATH 4-11-70 13:20 A.M.	
5. SEX F		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY 2505	
6. RACE W		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 4940 Pennington Ave.	
8. DATE OF BIRTH 6-5-88		9. AGE (In years last birthday) 81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JANKOWSKI		14. MOTHER'S MAIDEN NAME Z. UAK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-18-9132	
17. INFORMANT Family		ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cholecystitis - Biliary sepsis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Closed Liver Surgery	
20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4-9-70 19 70 to 4-11-70 19 70 that (I) (we) last saw the deceased alive on 4-11-70 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Daniel M. Howell		23B. DATE SIGNED 4-11-70	
23C. PHYSICIAN'S NAME (Type) Daniel M. Howell		23D. ADDRESS 132 W. Lafayette Ave. Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-15-70	
24C. NAME OF CEMETERY OR CREMATORY Meadowdale Cemetery		24D. LOCATION (City, town, or county) (State) Elkridge, Md	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.	
25C. FUNERAL DIRECTOR John H. Hahn		ADDRESS 4200 Pennington Ave	

Pennington Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-240 70 3869		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3869	
BIRTH NO. (Julia)		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Julia Ziejlo (ZIEJLO)</i>		2. DATE AND HOUR OF DEATH <i>12:00 midnight 4-11-70</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Balt. Gen. Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Baltimore</i>	
				B. COUNTY <i>2505</i>	
		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>1518 Cypress St.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-24-1885</i>	9. AGE (In years last birthday) <i>84</i>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Peter Katchur</i>			14. MOTHER'S MAIDEN NAME <i>Agatha ?</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Husband</i>		ADDRESS <i>Same</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>412.41-011.9</i>		CAUSE OF DEATH <i>ASCVD - congestive failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>Pulmonary Tuberculosis by x-ray</i>			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>9:41 4-10 1970</i> to <i>12:01 4-11 1970</i> that (I) (we) last saw the deceased alive on <i>4-10 1970</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Daniel M. Howell</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4-11-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Daniel M. Howell</i>		23D. ADDRESS <i>132 W. Lafayette Ave. Balt.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4-16-70</i>	24C. NAME of CEMETERY or CREMATORY <i>Holy Cross Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md. 21226</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 13 1970</i>	25B. NAME OF REGISTRAR <i>Robert E. Vaden, M.D.</i>	25C. FUNERAL DIRECTOR <i>John H. Hahn</i>		ADDRESS <i>4200 Pennington Ave.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

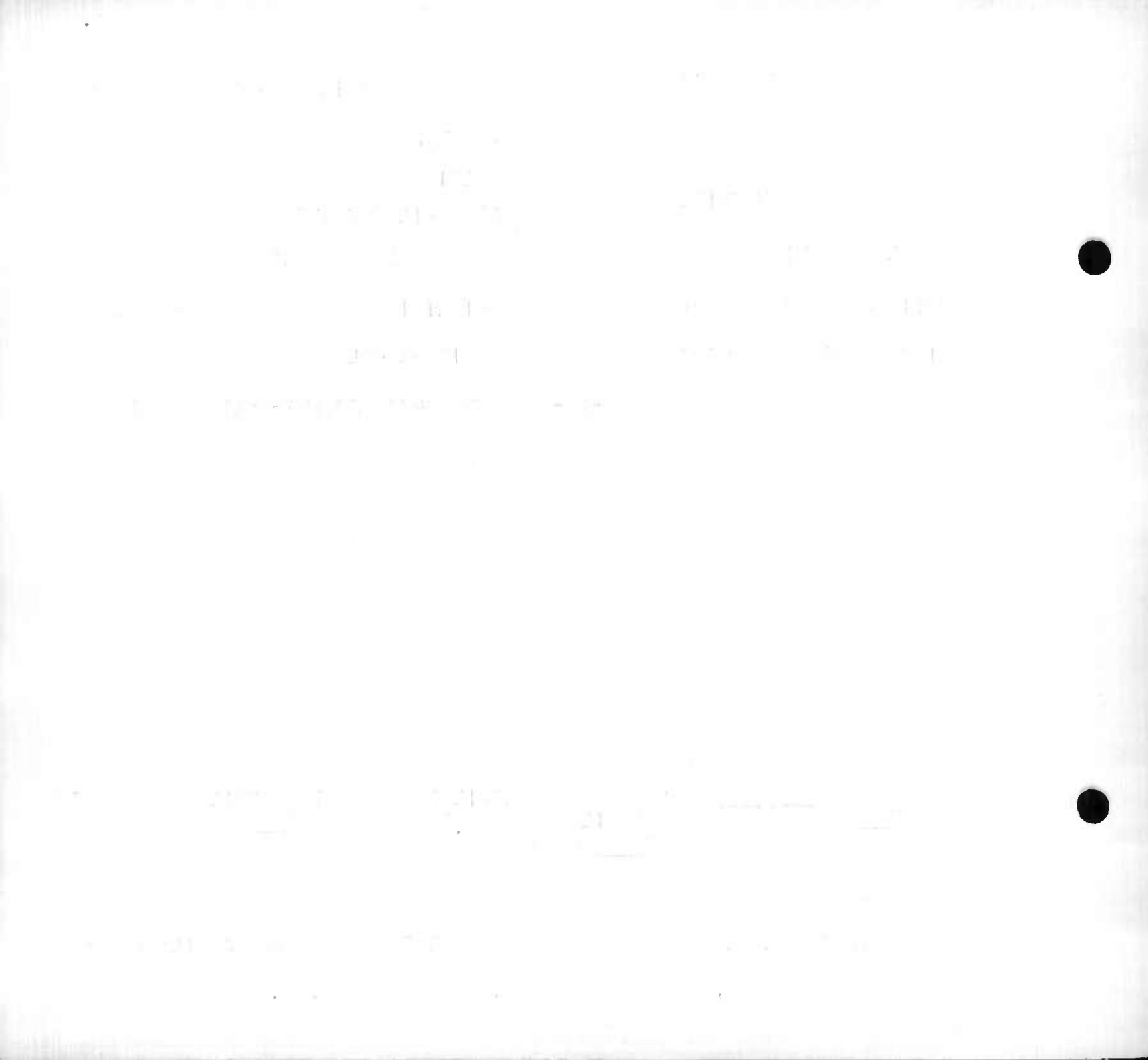
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3870	
BIRTH NO. A-255		70 3870		CERTIFICATE OF DEATH	
1. NAME OF DECEASED <small>(Type or Print)</small> HELEN ASIMENIOS			2. DATE AND HOUR OF DEATH 4-9-70 1:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Edgewood Nursing Home 6000 Bellona Avenue			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 600 Tolna Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-04	9. AGE (In years last birthday) 65	If Under 1 Yr. Months <input type="checkbox"/> Days <input type="checkbox"/> If Under 24 Hrs. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Greece	
13. FATHER'S NAME Demitri Samaras			14. MOTHER'S MAIDEN NAME Angeliki Smyrnioudis		
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> No		16. SOCIAL SECURITY NO. 214-22-1044		17. INFORMANT Michael Asimenios ADDRESS 600 Tolna Street, Baltimore, Md.	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</small> </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks ? </div> </div> <div style="margin-top: 10px;"> (A) IMMEDIATE CAUSE Sarcoma of abd. DUE TO, OR AS A CONSEQUENCE OF: (B) Sarcoma of intestine DUE TO, OR AS A CONSEQUENCE OF: (C) </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-5 1970 to 4-9 1970 that (I) (we) last saw the deceased alive on 4-5 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Volmer M.D.				23B. DATE SIGNED 4-9-70	
23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLMER M.D.			23D. ADDRESS 6100 York Rd		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-11-70		24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Nicholas J. Matthews ADDRESS 3021 Eastern Ave., Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 5-562		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3871	
1. NAME OF DECEASED (Type or Print) SUMMERS, DORA CONSTANCE			2. DATE AND HOUR OF DEATH APRIL 8, 1970 6:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2551 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3404 WILKENS AVE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03 06 87	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED NURSE			10B. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME RICHARD HENRY SUMMERS		
14. MOTHER'S MAIDEN NAME ANNIE PANGEL			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		
16. SOCIAL SECURITY NO. 218-30-6922			17. INFORMANT ADDRESS ST AGNES RECORDS-BALTO MD 21229		
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.C.V.D. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 7 19 70 to APRIL 8 19 70 that (I) (we) last saw the deceased alive on APRIL 8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE D Shams M.D.		23B. DATE SIGNED 4-8-70		23C. PHYSICIAN'S NAME (Type) A SHAMS, M.D.	
23D. ADDRESS ST AGNES HOSP CATON & WILKENS AVE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE April 11, 1970		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.		24D. LOCATION Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Sauer, R.D.		25C. FUNERAL DIRECTOR C. T. Simon	
25D. ADDRESS Schwartz Funeral Home					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 3872	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) NANCY- DONALD.		2. DATE AND HOUR OF DEATH 12³⁰ PM 4/17/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinci hospital, greenspring, MD. 21215		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1510 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4002 Oakford Avenue Apt A.			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/19/27	9. AGE (In years last birthday) 42
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Allen Aaron			
14. MOTHER'S MAIDEN NAME Nannie L. Starks		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.			
16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. Nannie Aaron ADDRESS 4002 Oakford Ave. Apt A			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Massive acute Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF: (B) Possible Pulvic Thrombophlebitis DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			SLE (Systemic Lupus Erythematosus) ?		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/23 19 70 to 4/17 19 70 that (I) (we) last saw the deceased alive on 11 AM, 4/17 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Hoorazar 9068 M.D.				23B. DATE SIGNED 4/17/70	
23C. PHYSICIAN'S NAME (Type) HOORAZAR, 9068 M.D.				23D. ADDRESS Sinci hospital, MD. 21215, Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/11/70		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 13 1970			
25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR Nutter Funeral Home ADDRESS 3035 W. North Avenue			



FUNERAL DIRECTOR: IMPORTANT

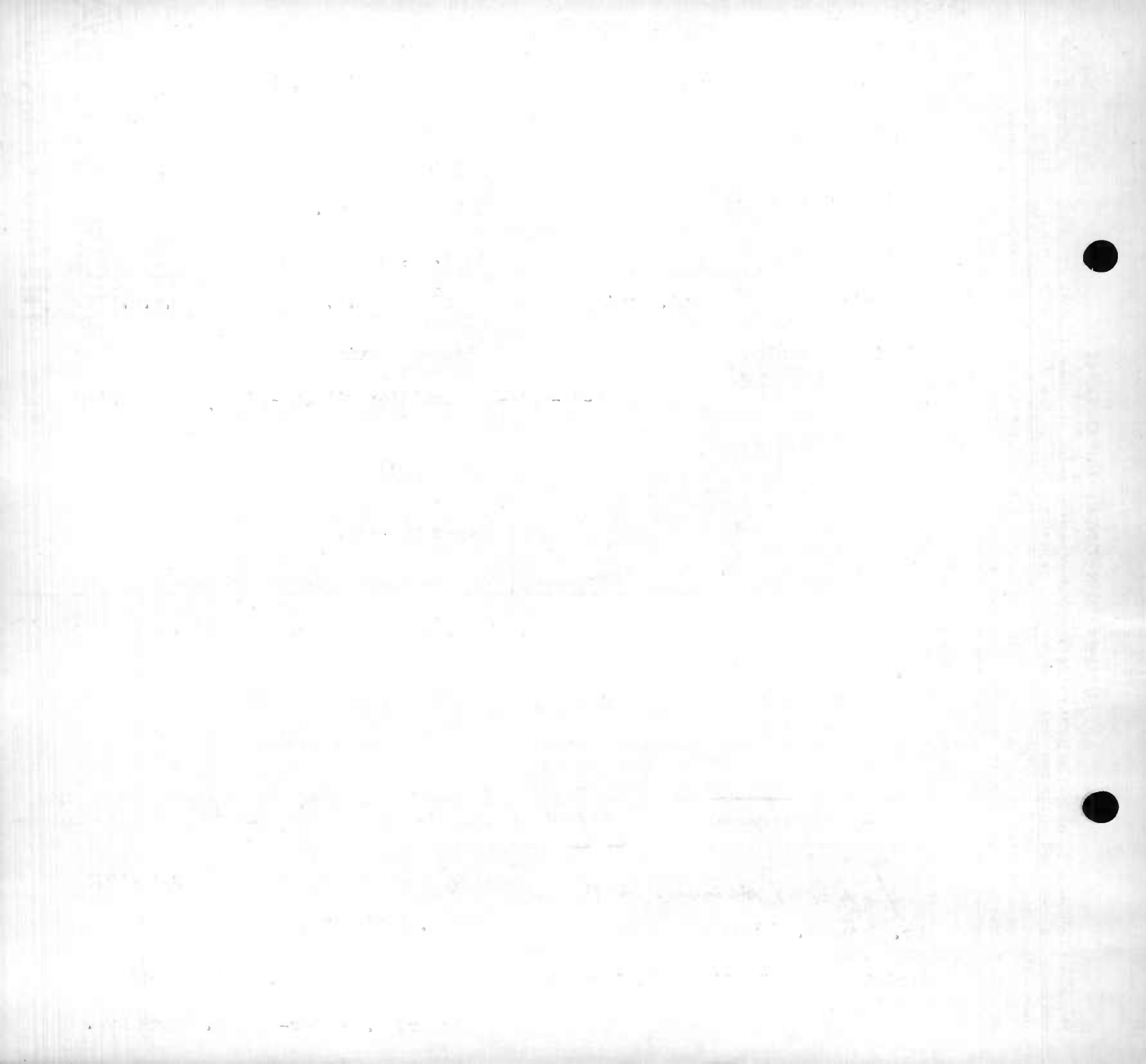
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-523 70 3873		BALTIMORE CITY HEALTH DEPARTMENT		70 3873	
BIRTH NO.			REG. NO.		
1. NAME OF DECEASED (Type or Print) PINKETT, CORA V.			2. DATE AND HOUR OF DEATH 11:45 PM 4-8-70		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			A. STATE MARYLAND B. COUNTY 1204		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 2334 BARCLAY STREET		
5. SEX F.	6. RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-87	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY Domestic - Pvt Family		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME RICHARD GROSS			14. MOTHER'S MAIDEN NAME MARY James		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-32-0948		
17. INFORMANT Mr. & Mrs. Harry A. Skinner			ADDRESS 2334 Barclay St.		
18. 44501 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia, Respiratory arrest			few months		
(B) Gangrene left foot DUE TO, OR AS A CONSEQUENCE OF:			6-8 weeks		
(C) Arteriosclerotic Cardiovascular system disease Diet			years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 3-12-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene left foot		20A. AUTOPSY? (Yes or No) -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3-10-70 19 to 4-8 19 70 that (I) (we) last saw the deceased alive on 10pm 4-8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Moazzenzadeh			23B. DATE SIGNED 4-8-70		
23C. PHYSICIAN'S NAME (Type) A. MOAZZENZADEH, M.D.			23D. ADDRESS THE UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/70		24C. NAME OF CEMETERY OR CREMATORY Brooks Chapel	
24D. LOCATION Calvert Co., Maryland		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Nutter Funeral Home ADDRESS 3035 W. North Avenue	

THE UNIVERSITY OF CHICAGO

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3874	
E-363 70 3874		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Lena Edwards		2. DATE AND HOUR OF DEATH April 9, 1970 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1416 Myrtle Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1402 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1416 Myrtle Ave.	
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1886
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family	9. AGE (In years last birthday) 83
11. BIRTHPLACE (State or foreign country) Oxford N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Braxton		14. MOTHER'S MAIDEN NAME Emma Davis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-30-5238-A	
17. INFORMANT Mckinley Wilson		ADDRESS -740 E. Cold Spring Lane	
18. 4/12/70 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ASHD ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Viral infection - upper respiratory	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR?	(If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 19 69 to April 19 70 , that (I) (we) last saw the deceased alive on April 1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jesse T. Holmes M.D.		23B. DATE SIGNED 4/10/1970	23C. PHYSICIAN'S NAME (Type) Dr. Jesse T. Holmes MD
23D. ADDRESS 508 E. North Avenue		23E. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/13/1970	24C. NAME OF CEMETERY or CREMATORY Family Lot	24D. LOCATION (City, town, or county) (State) Durham, North Carolina
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970	25B. NAME OF REGISTRAR Herb E. Nutter	25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

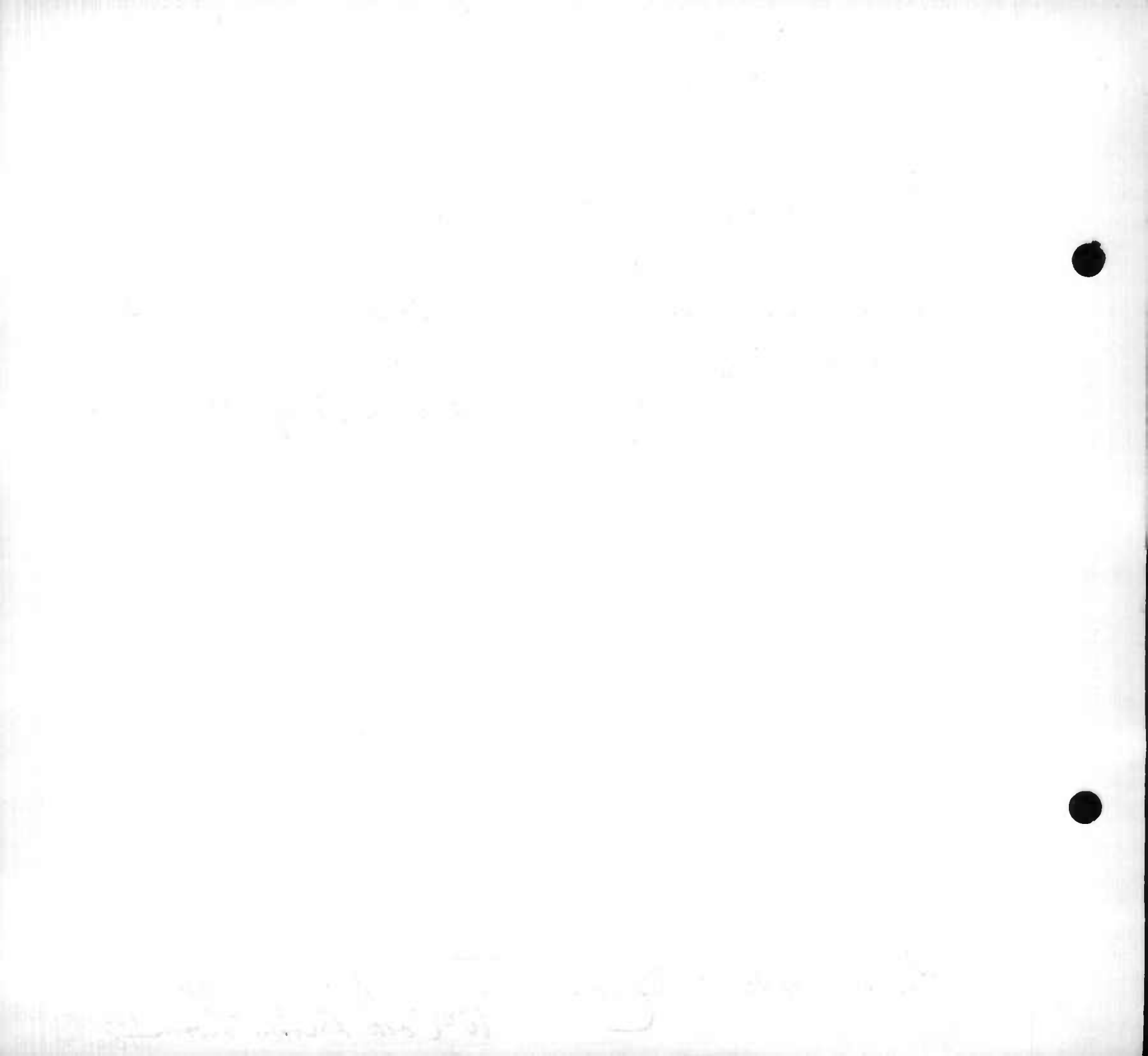
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
K-400		70 3875		70 3875	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
KELLY, LEOLA			APRIL 8, 1970 10:05 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 21229, MD.			A. STATE MARYLAND B. COUNTY 2006		
5. SEX FEMALE			6. RACE NEGRO		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 02/06/24		
9. AGE (In years lost birthday) 46			10. BIRTHPLACE (State or foreign country) ALABAMA		
11. BIRTHPLACE (State or foreign country) ALABAMA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Leevester HARMON			14. MOTHER'S MAIDEN NAME LUCILLE W. (WRIGHT)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 114-18-6628D		
17. INFORMANT Mrs. Lucille Shorts 331 S. Ellamont St. ST. AGNES HOSPITAL, WILKENS & CATON AVE.			ADDRESS		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Malignant hypertension DUE TO, OR AS A CONSEQUENCE OF: (C)		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) YES			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from APRIL 06 1970 to APRIL 08 1970 that (I) (we) last saw the deceased alive on APRIL 08 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE CHING-HUI TSAI, M.D.			23B. DATE SIGNED 4/9/70		
23C. PHYSICIAN'S NAME (Type) CHING-HUI TSAI, M.D.			23D. ADDRESS St Agnes Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/13/70		
24C. NAME OF CEMETERY or CREMATORY Western Star Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland		
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970			25B. NAME OF REGISTRAR Edith E. Taylor, R.D.		
25C. FUNERAL DIRECTOR Nutter Funeral Home			ADDRESS 3035 W. North Avenue		

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3876	
P-426 70 3876 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John Pilker</i>		2. DATE AND HOUR OF DEATH <i>4/9/70 6³⁰ P.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View Nurs. Home</i>			A. STATE <i>MD</i> B. COUNTY <i>City</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1213 Light St</i>			C. CITY OR TOWN <i>Belts</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>M</i> 6. RACE <i>W</i>			E. STREET AND NUMBER <i>2237 Annapolis Rd</i>		
MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (in years last birthday) <i>76</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Window Cleaner</i>			11. BIRTHPLACE (State or foreign country) <i>MD</i>		
10B. KIND OF BUSINESS OR INDUSTRY <i>Baumgardner</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Wm. Pilker</i>			14. MOTHER'S MAIDEN NAME <i>Mary Fealey</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>215-10-5813</i>		
17. INFORMANT <i>Bessie E Long</i>			ADDRESS <i>Same as 4</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>412.4 I</i>			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <i>Terminal Pulmonary Pneumonia</i>		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <i>ASC. V. Disease</i>		
			(C) <i>Cerebral Insufficiency</i>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<i>Hydr. CVA</i>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>4/3</i> 19 <i>70</i> to <i>4/9</i> 19 <i>70</i> that (I) (we) lost saw the deceased alive on <i>4/6</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joseph S. Blum MD</i>				23B. DATE SIGNED <i>4/10/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOSEPH S. BLUM MD</i>				23D. ADDRESS <i>1115 N CALVERT ST</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>4-13-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Meadowridge</i>	
24D. LOCATION <i>Worsey</i>		24E. CITY, town, or county <i>Howard Co Md</i>		24F. STATE <i>MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 13 1970</i>		25B. NAME of REGISTRAR <i>John E. Fisher, Jr.</i>		25C. FUNERAL DIRECTOR <i>1022 Cook Brooks Towson</i>	
25D. ADDRESS <i>1050 York Rd</i>		25E. CITY, town, or county <i>Towson</i>		25F. STATE <i>MD</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3877	
M-240 70 3877		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Mary T. Michael		April 9, 1970 6:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital			A. STATE Maryland		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			C. CITY OR TOWN Baltimore		
			E. STREET AND NUMBER 4216 Parkmont Ave		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1895	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Kuntz		14. MOTHER'S MAIDEN NAME Anna Hasek	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220 09 0896		17. INFORMANT Theresa Oktavec	
				ADDRESS 5929 Greenhill Ave.	
18. 4/10/70 I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Myocardial Infarction		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Cardiovascular CVD		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 9 1970 to April 9 1970, that (I) (we) last saw the deceased alive on April 9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE J. Henry Haase				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) J. Henry Haase				23D. ADDRESS 2576 E. Calverton Rd. Baltimore Md	
24A. BURIAL CREMATION REMOVAL (Specify) Burial	24B. DATE 4-13-70	24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Embury		24D. LOCATION (City, town or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. APR 13 1970		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR [unclear]	
				ADDRESS 1211 Clatsco Ave.	

USA

Handwritten

Notes

Handwritten notes and text, including "Handwritten" and "Notes".

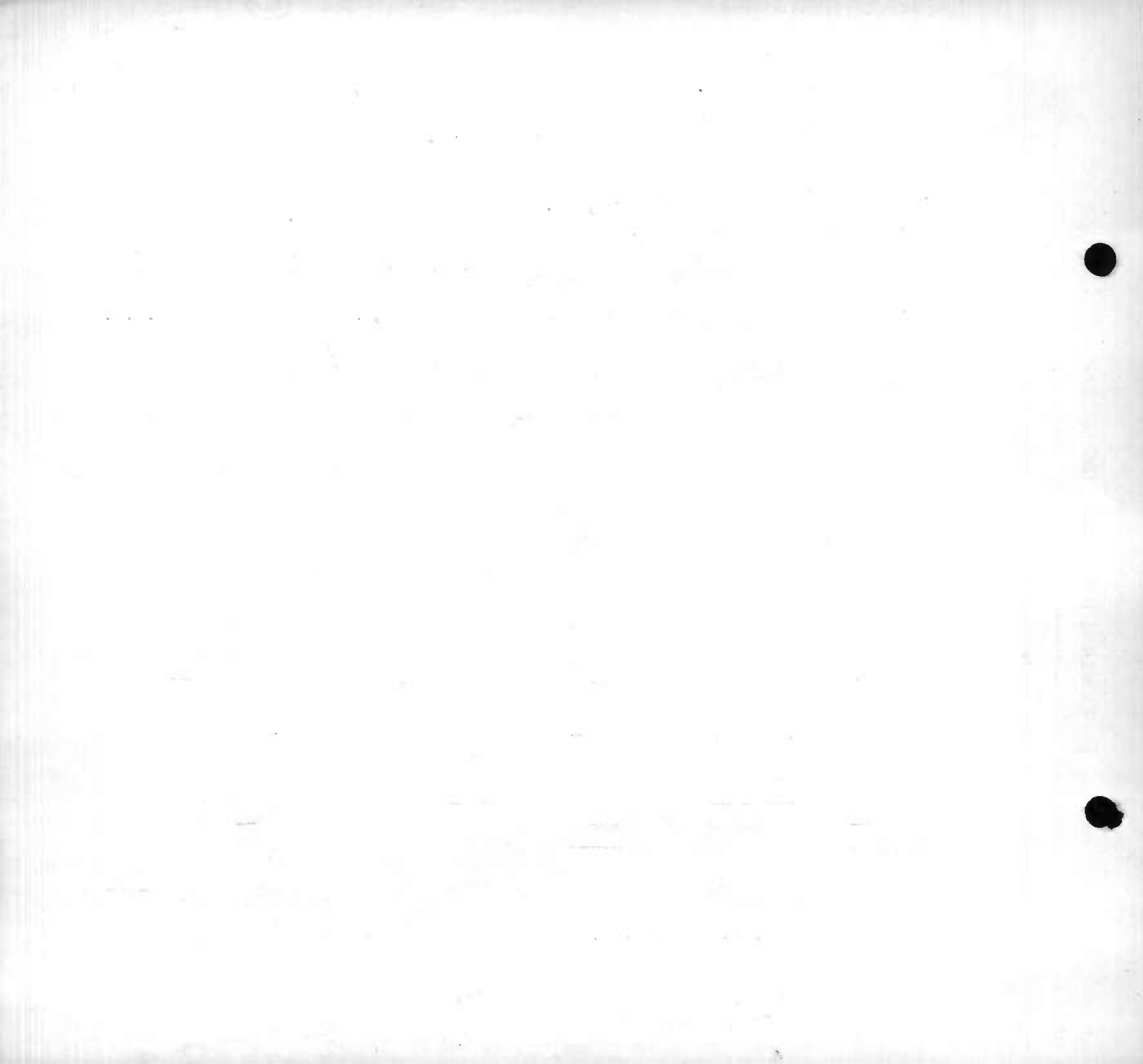
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

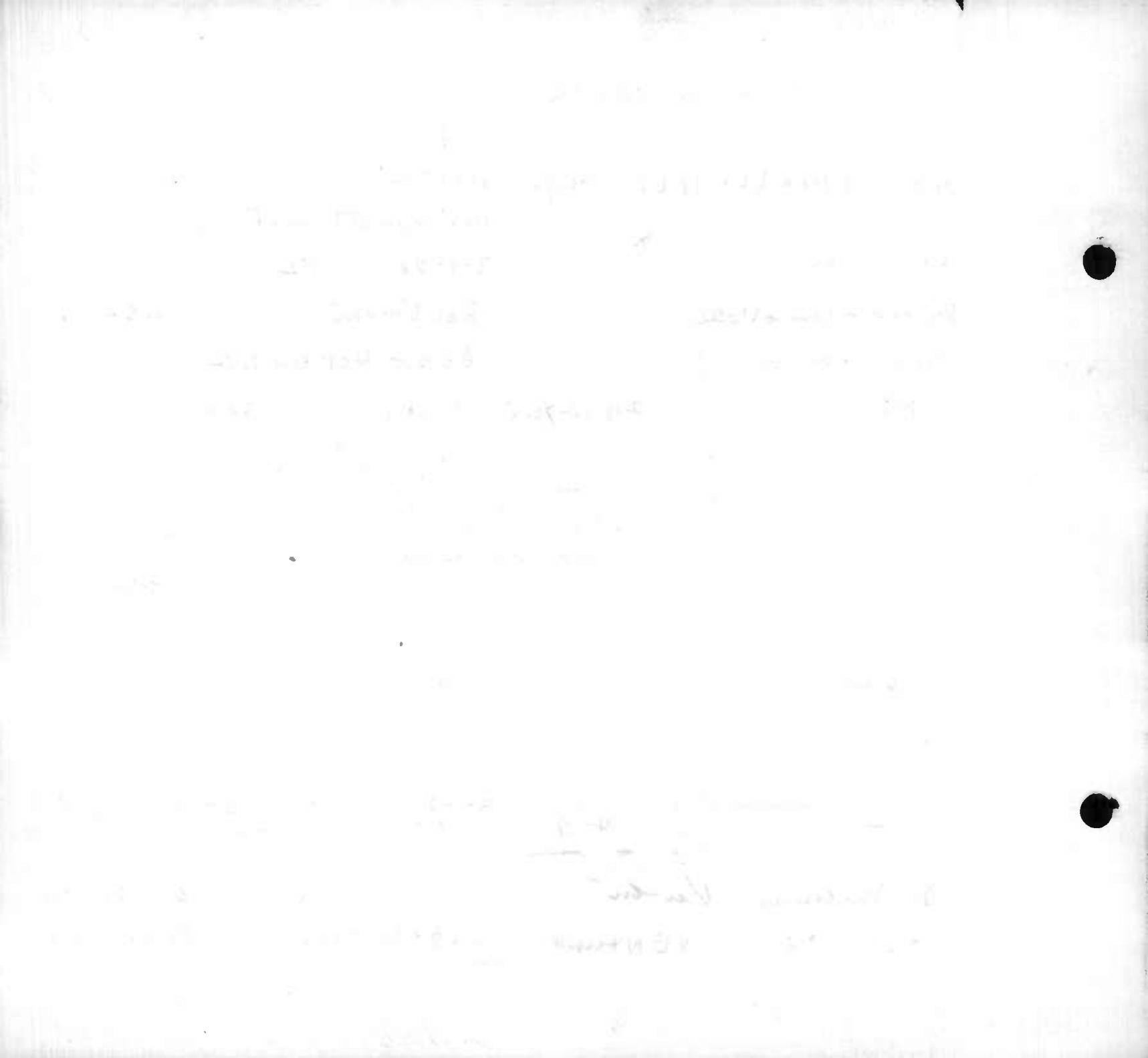
BALTIMORE CITY HEALTH DEPARTMENT									
C-500 70 3878					REG. NO. 70 3878				
BIRTH NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) LAWRENCE M. CONWAY					2. DATE AND HOUR OF DEATH 4/10/70 5:20 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) I626 CLARKSON STREET BALTIMORE, MD.					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER I626 CLARKSON ST.									
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/1900	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR			10B. KIND OF BUSINESS OR INDUSTRY TRUCKING		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME LAWRENCE CONWAY			14. MOTHER'S MAIDEN NAME AGNES HARGAN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 212 10 5734 A			17. INFORMANT SOPHIA CONWAY ABOVE ADDRESS			ADDRESS			
18. 185 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cancer of prostate gland, with general metastasis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ---		20A. AUTOPSY? (Yes or No) no.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ---			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ---					
21D. TIME OF INJURY (APPRDX.) (Month) (Day) (Year) (Hour) ---		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? ---					
22. I certify that (I) (this hospital) attended the deceased from 1-30-1960 to 4-9-1970 , that (I) (we) last saw the deceased alive on 4-9-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE C. C. Chiu					23B. DATE SIGNED 4-11-70			23C. PHYSICIAN'S NAME (Type) C. C. Chiu, M. D.	
23D. ADDRESS 1 E. Randall Street, Baltimore 21230									
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/14/70		24C. NAME OF CEMETERY or CREMATORY HOLY CROSS CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR James E. Taylor		25C. FUNERAL DIRECTOR 130 E. Fort Ave		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

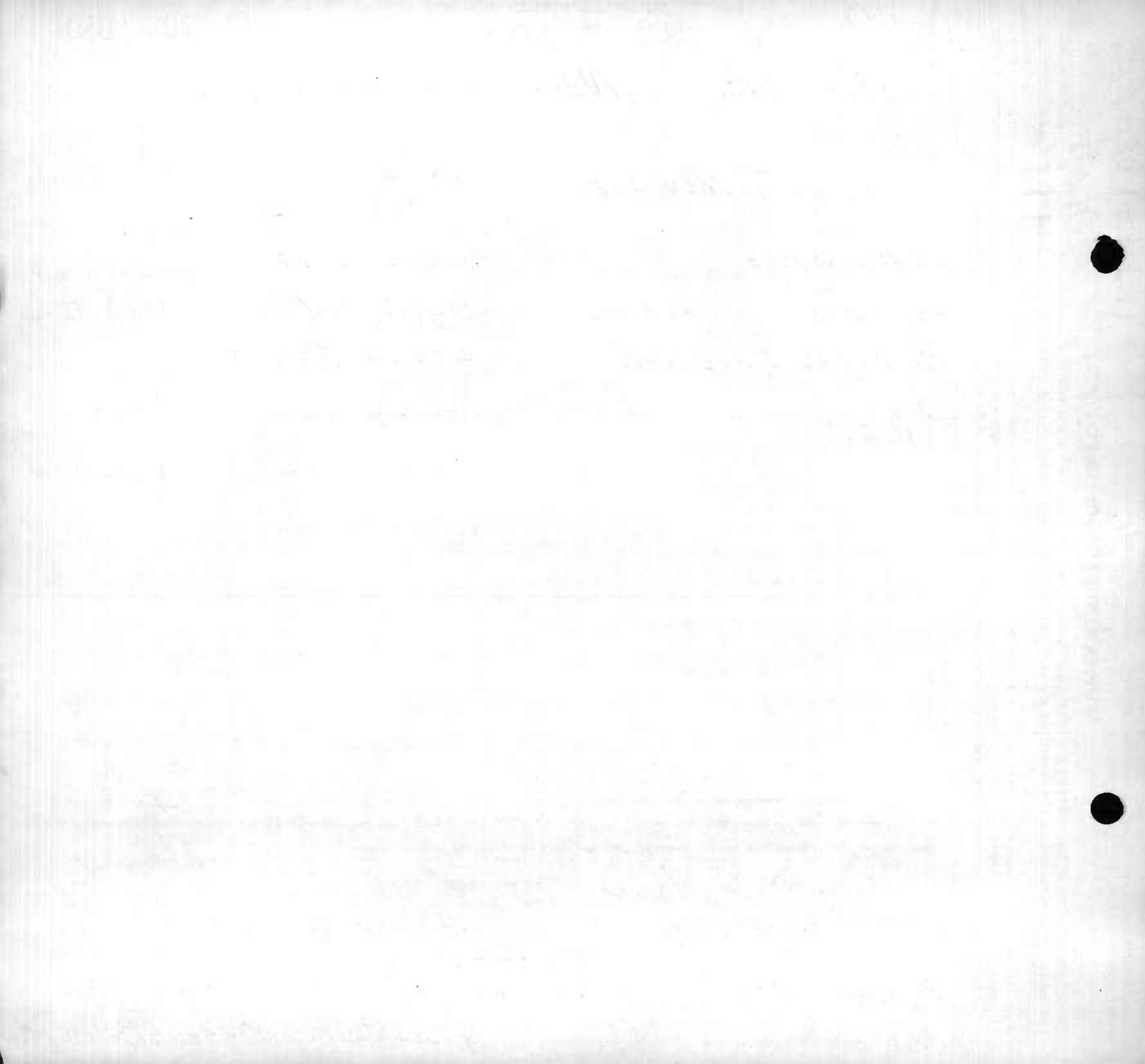
M-200		70 3879		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3879	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type as Print) WILLIAM L. MEEK				2. DATE AND HOUR OF DEATH 4-9-70 3:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 905			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GLEN Hosp. 49				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1155 Homestead ST			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-9-98	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - ARMCO STEEL				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State as foreign country) BALTIMORE	
13. FATHER'S NAME WILLIAM W. MEEK				14. MOTHER'S MAIDEN NAME ANNA HORNUNG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 218-14-7805		17. INFORMANT WIFE ADDRESS SAME	
18. 155.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hepatitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis, severe Pulmonary edema + congest				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatitis (B) DUE TO, OR AS A CONSEQUENCE OF: Generalized arteriosclerosis, severe (C) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary edema + congest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2 Nov		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-28 19 70 to 4-9 19 70 that (I) (we) last saw the deceased alive on 4-9 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Melencio Venturi DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-9-70	
23C. PHYSICIAN'S NAME (Type) MELENCIO VENTURI DEGREE				23D. ADDRESS NORTH CHARLES GLEN Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-13-70		24C. NAME OF CEMETERY or CREMATORY MEADOWRIDGE MEMORIAL		24D. LOCATION (City, town, or county) (State) HOWARD Co., MD	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Paul E. Taylor, R.D.		25C. FUNERAL DIRECTOR J. Walter Conklin ADDRESS 5444 BELAIR Rd			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

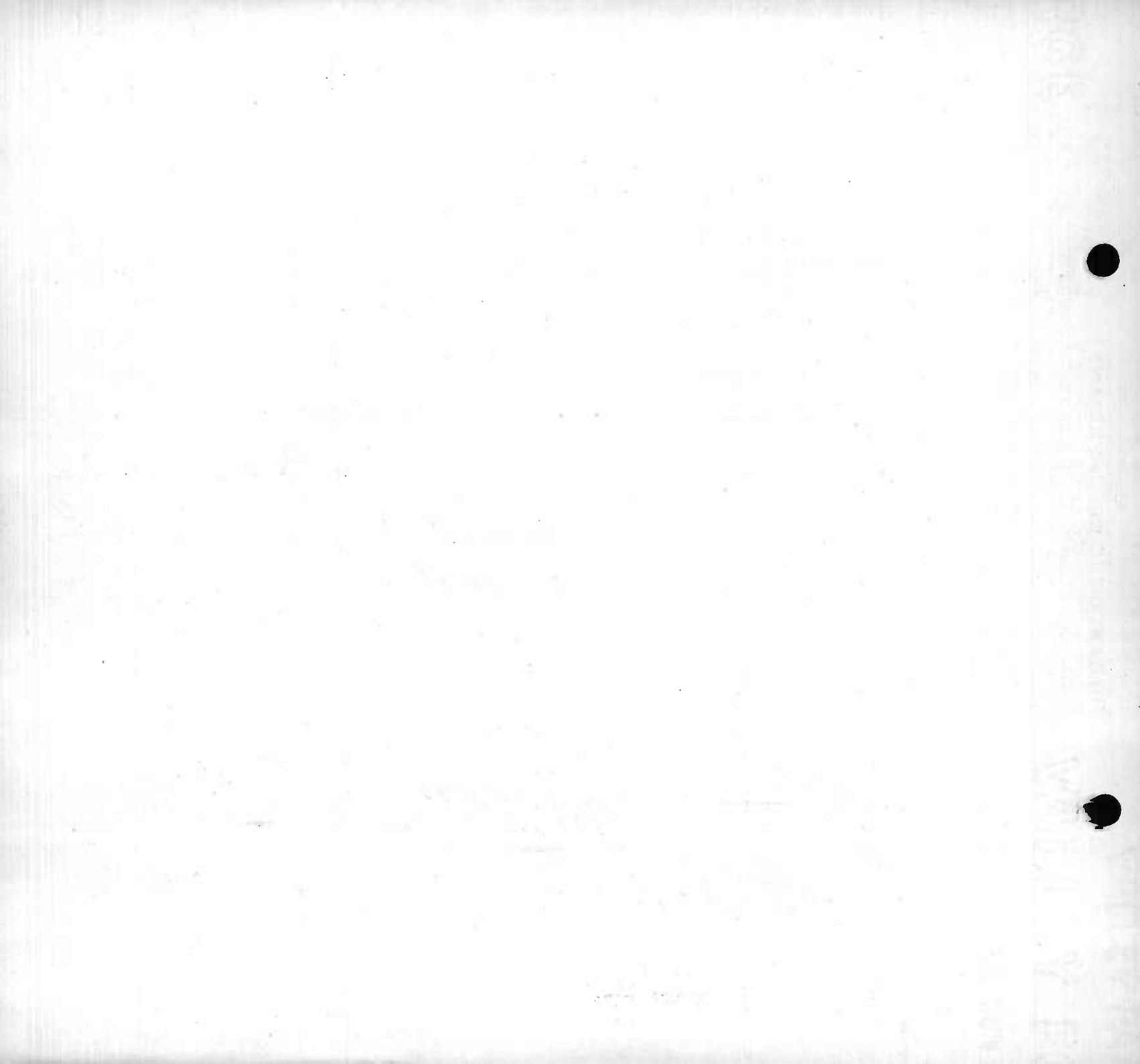
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3880
N-160 70 3880 BIRTH NO.		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) MARIE A. NEUBAUER		2. DATE AND HOUR OF DEATH APRIL 10, 1970 1:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2725 TIVOLY AVE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD 8. COUNTY 906 C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2725 TIVOLY AVE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 25, 1904 66	9. AGE (In years lost birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTO, MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HENRY W. BATEMAN		
14. MOTHER'S MAIDEN NAME LOUISA HARPS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 214-01-7234		17. INFORMANT FAMILY ADDRESS SAME		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 162.1 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF: (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 6 yrs		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from 1960 to Death 1970, that (I) (we) last saw the deceased alive on 10/1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.				
23A. SIGNATURE Emmett P. Davis		23B. DATE SIGNED 4/10/70		23C. PHYSICIAN'S NAME (Type) Emmett P. Davis
23D. ADDRESS 5317 Belair Road 21206		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 4-13-70		24C. NAME OF CEMETERY or CREMATORY MEADOW RIDGE MEM. PARK		
24D. LOCATION (City, town, or county) (State) Howard Co., Md.		25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS J. Walter Conklin 5444 BELAIR RD.		



FUNERAL DIRECTOR: IMPORTANT


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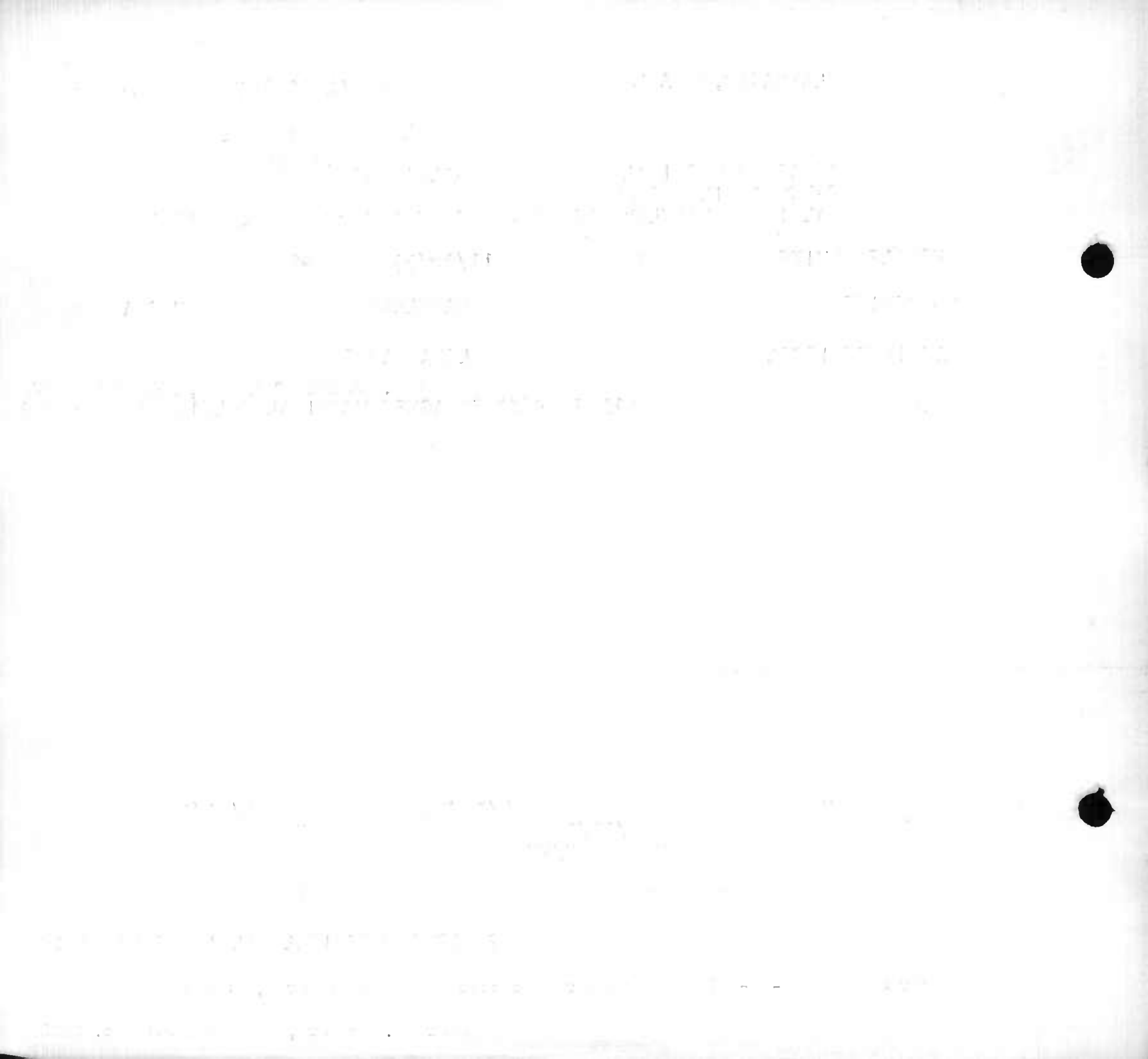
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 3881	
7-600 70 3881							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDITH A. THAYER			2. DATE AND HOUR OF DEATH 4/9/70 12:17 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF Md. Hospital 22 S. Greene ST. BALTO. Md.				C. CITY OR TOWN Woodlawn		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6703 Windsor Mill Road			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 4/19/16	9. AGE (In years last birthday) 53	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Martin				14. MOTHER'S MAIDEN NAME Addie Garland			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212.01.6345		17. INFORMANT Wayne Thayer		ADDRESS 6617 Bowman Hill Road	
18. 485 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
				(B) Bilateral Bronchopneumonia		36 hrs	
				(C) Dehydration		48 hrs	
II				Regional Enteritis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION None this admission		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Regional Enteritis		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) NONE		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/7/70 19 to 4/9/70 19, that (I) (we) lost saw the deceased alive on 4/9/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE George M. Tucker, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/9/70	
23C. PHYSICIAN'S NAME (Type) George M. Tucker				23D. ADDRESS 6411 Windsor Mill Rd.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/70		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR James E. Sabin, M.D.		25C. FUNERAL DIRECTOR John T. Stauping		ADDRESS 6411 Windsor Mill Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3882</u>	
F-452 BIRTH NO. <u>70 3882</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FLANNAGAN, ANNA M		2. DATE AND HOUR OF DEATH APRIL 11 1970 9:20AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore 53.00 C. CITY OR TOWN HALETHORPE D. INSIDE CITY LIMITS? BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5635 ASHBOURNE ROAD 21227			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/77	9. AGE (In years last birthday) 92	10. Under 1 Yr. Months 1 Yr. Days 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME MARTIN STRIEGEL			
14. MOTHER'S MAIDEN NAME LENA KASPER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 213 52 9659		17. INFORMANT MRS. OLOIVIA GOODRICH, 5635 ASHBOURNE ST AGNES HOSPITAL BALTIMORE MD 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I CAUSE OF DEATH Cardiac stand. Still. shock. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Complete Atrial ventricular Block (B) DUE TO, OR AS A CONSEQUENCE OF: A. S. C. V. D. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days -		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>4/10/70</u> 19 to <u>4/11/70</u> 19 that (X) (we) lost saw the deceased alive on <u>4/11/70</u> 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (We) (did) (X) (X) (X) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA M.D.	
23D. ADDRESS ST AGNES HOSPITAL BALTIMORE MD 21229		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 4-14-1970		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR PAUL E. J. HUBBARD		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

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<p>K-520 70 3883</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 70 3883</p>	
<p>BIRTH NO.</p>		<p>2. DATE AND HOUR OF DEATH</p> <p>4/7/70 12 Noon</p>	
<p>1. NAME OF DECEASED (Type or Print) Kines, Irene Honora</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE Md. B. COUNTY</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>40 St. Agnes Hospital</p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 2507 Guilford Ave. 21218</p>	
<p>5. SEX Female</p>	<p>6. RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH Oct. 19, 1904</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker</p>		<p>11. BIRTHPLACE (State or foreign country) Pennsylvania</p>	
<p>13. FATHER'S NAME John L. Sullivan</p>		<p>14. MOTHER'S MAIDEN NAME Honora Spleen</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. - - -</p>	
<p>17. INFORMANT Mr. Charles R. Kines 2507 Guilford Avenue</p>		<p>ADDRESS</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH Acute Coronary Occlusion (A) IMMEDIATE CAUSE Marked Pulmonary Emphysema DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic C.V. Disease</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 31 Mar. 19 60 to 7 April 19 70</p> <p>that (I) (we) last saw the deceased alive on 11/11 19 69 and that in (my) (our) opinion death occurred on the date 7 April 19 70</p> <p>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>23A. SIGNATURE Joseph E. Muse Jr MD</p>		<p>23B. DATE SIGNED 7 April '70</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>		<p>23D. ADDRESS 901 Pine Hts. Ave. Balto 29 Md.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 10 APR 70</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. APR 14 1970</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor</p>	
<p>25C. FUNERAL DIRECTOR J. E. Lowell</p>		<p>ADDRESS Lemmon 46 bl Park Hgts. Av</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 3884</u>	
H-236 70 3884		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JAMES HESTER		2. DATE AND HOUR OF DEATH APRIL 9, 1970 11:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) NORTH CHARLES GENERAL HOSP.		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE MARKLAND B. COUNTY 27-16 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4677 Park Heights Ave.	
5. SEX Male	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-09 9. AGE (In years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10B. KIND OF BUSINESS OR INDUSTRY School Board	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN PRYOR HESTER	
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 237 09 48 52		17. INFORMANT ADDRESS Mrs. Anna Hester 4677 Park Heights AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OAT CELL LUNG CARCINOMA		2 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Thoracotomy, Anemia			
19A. DATE OF OPERATION 4-9-70	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF LUNG	20A. AUTOPSY? (Yes or No) NO.	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb. 14 19 70 to April 9 19 70 that (I) (we) last saw the deceased alive on April 9 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Feodor C. Caguin, M.D.		23B. DATE SIGNED April 9, 1970	
23C. PHYSICIAN'S NAME (Type) FEODOR C. CAGUIN, M.D.		23D. ADDRESS 336 E. 25th ST., BALTIMORE, Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 11 APR 70	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	24D. LOCATION (City, town, or county) (State) Westport, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR J. E. Lowell Lemmon	
25C. FUNERAL DIRECTOR J. E. Lowell Lemmon		ADDRESS 4611 Park Heights Ave.	

1-2-4

MALE

BALTIMORE

4212 PARK HEIGHTS AVE

1-1-41

IN RTH CHARLES GENERAL

HOSP

Male colored

CUSTODIAN

JOHN BRICK

ARTERIO SCLEROTIC CARDIO -
VASCULAR DISEASE

OUT CELL LUNG CARCINOMA

Throatectomy, Anemia

4-4-50 CANCER

April 4 1950
Feb 14 1950

[Signature]

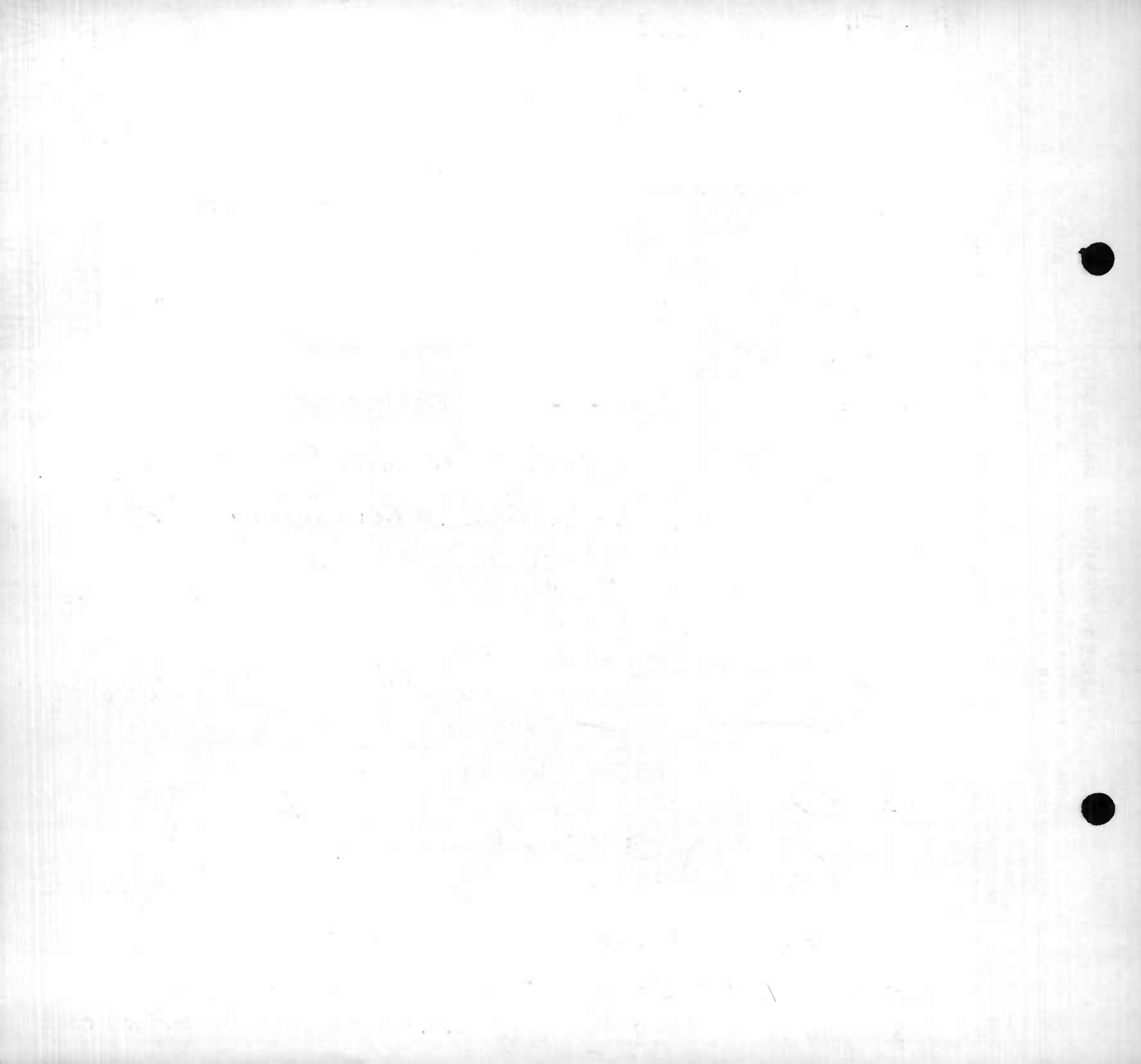
FEDOR C CAGIN MD

330 E 25th ST, BALTIMORE MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

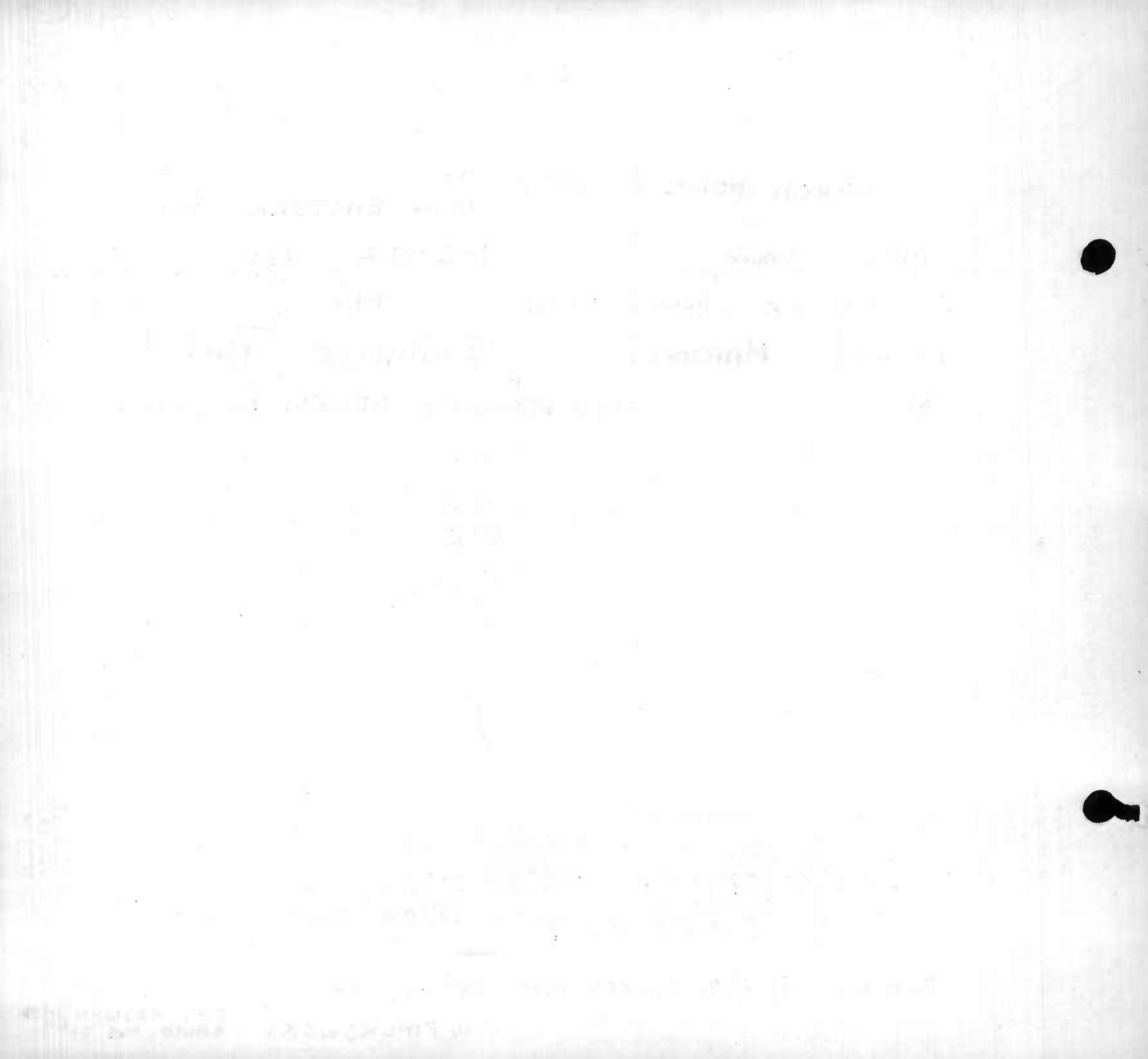
M-634 70 3885		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3885	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH J. MARTEL		2. DATE AND HOUR OF DEATH April 10 1970 4 ⁰⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2902 Alvarado Sq.		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md B. COUNTY 2757 C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2902 Alvarado Square			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 29 1906	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY auto		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph Martel		14. MOTHER'S MAIDEN NAME Marie *****	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-32-2486		17. INFORMANT Family records ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.2 I CAUSE OF DEATH Cerebro Vascular Occlusion (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cerebrovascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular Disease (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr.		19. DATE OF OPERATION		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1963 to Apr 1970, and that (I) (we) lost saw the deceased alive on Apr 9 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Frank T. Kasik, Jr., MD		23B. DATE SIGNED 4/12/70	
23C. PHYSICIAN'S NAME (Type) Frank T. Kasik, Jr., MD		23D. ADDRESS 9005 Harford road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/70		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION Balto Co Md.		24E. DATE REC'D BY HEALTH DEPT. APR 14 1970		24F. NAME OF REGISTRAR C.F. EWANS & SON	
24G. FUNERAL DIRECTOR ADDRESS C.F. EWANS & SON 8802 Harford road		24H. DATE REC'D BY HEALTH DEPT. APR 14 1970		24I. NAME OF REGISTRAR C.F. EWANS & SON	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

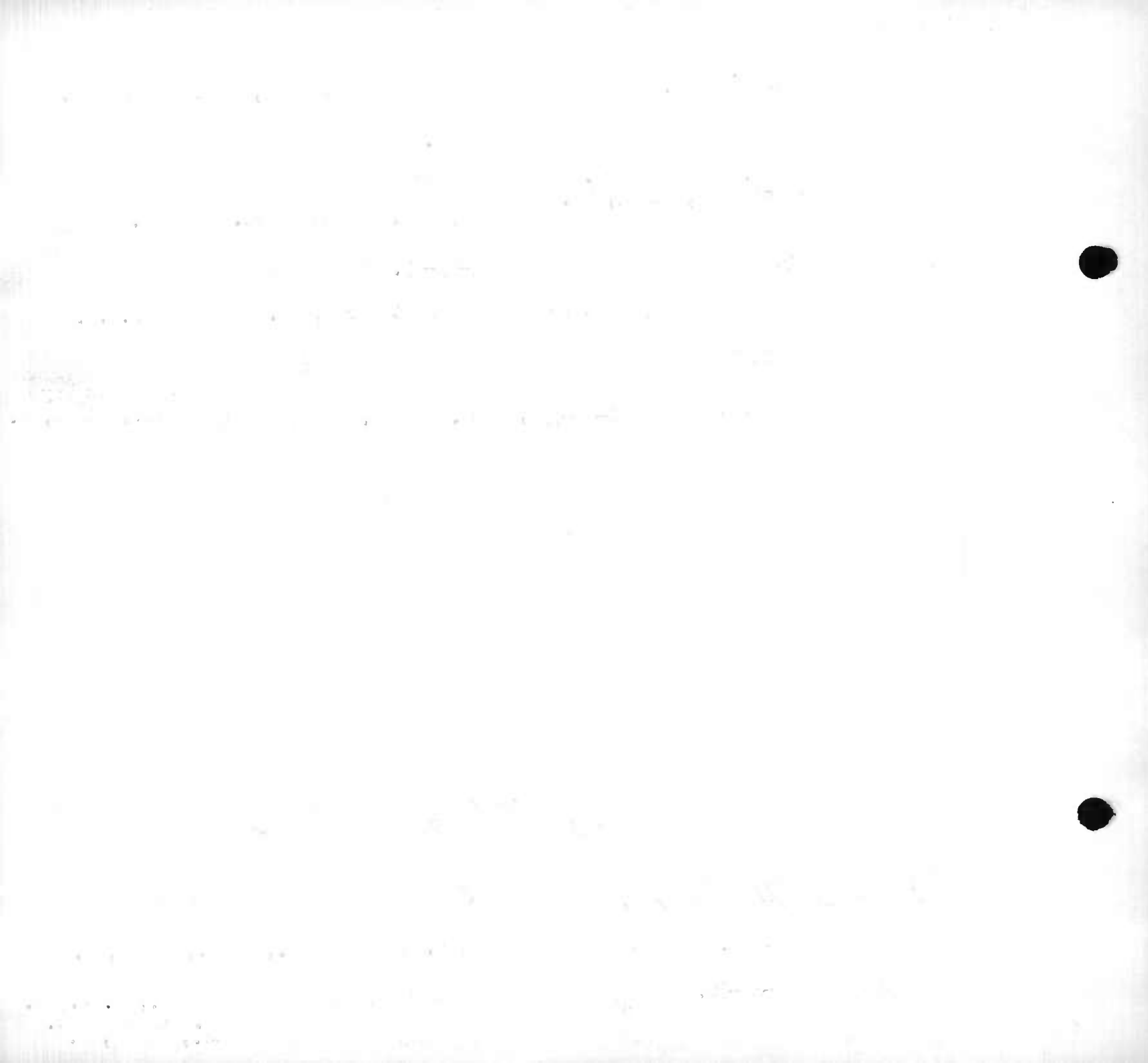
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3886	
M-632 (FELIX) 3886		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) FELICE R. MARTOCCI		2. DATE AND HOUR OF DEATH 4-10-70 10:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 35 Church Home & Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 21231	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hosp.		C. CITY OR TOWN BALTO.	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1914 EASTERN AVE.	
5. SEX MALE	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-02
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COORDINATOR		10B. KIND OF BUSINESS OR INDUSTRY ALLIED CONST.	9. AGE (In years lost birthday) 68
		11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PATRICK MARTOCCI		14. MOTHER'S MAIDEN NAME ISABELLE PADULA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. A. 218-18-6930	
		17. INFORMANT WIFE HELEN MARTOCCI	
		ADDRESS 1914 EASTERN AVE.	
18. 4-10-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (or any of them) (B) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
MEDICAL CERTIFICATION		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Previous Myocardial Infarction	
19A. DATE OF OPERATION 0 NOV 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 19 69 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Gottlieb C. Fajersinger MD		23B. DATE SIGNED 4/11/70	
23C. PHYSICIAN'S NAME (Type) Gottlieb C. Fajersinger		23D. ADDRESS Johns Hopkins Hospital Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/14/70	
24C. NAME OF CEMETERY or CREMATOR SACRED HEART OF MARY		24D. LOCATION (City, town, or county) (State) BALTIMORE CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR W. FIALKOWSKI		ADDRESS 2007 EASTERN AVE. BALTO. MD. 21231	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

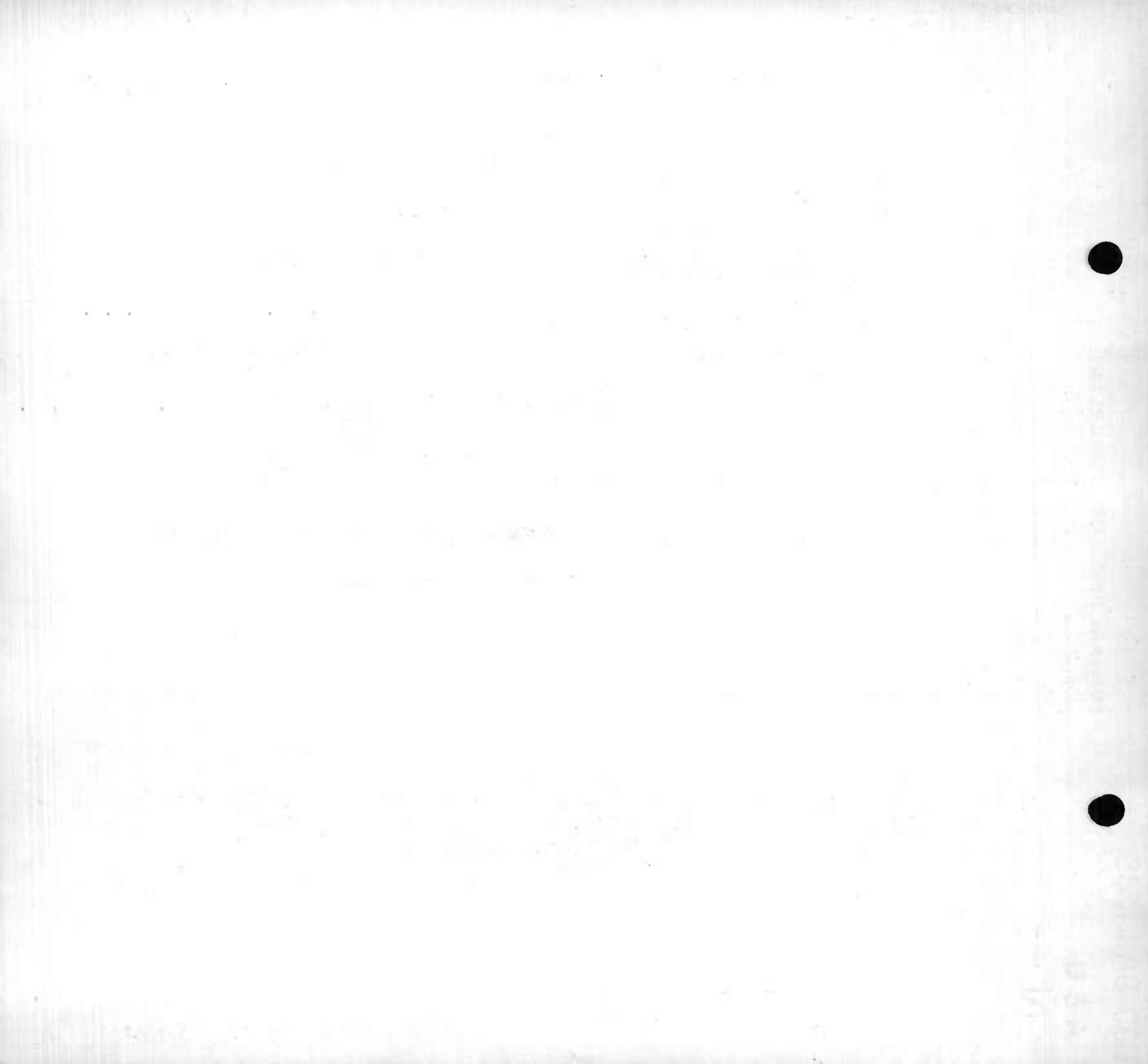
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3887</u>	
<div style="display: flex; justify-content: space-between;"> W-452 CERTIFICATE OF DEATH </div>					
BIRTH NO. <u>70 3887</u>		1. NAME OF DECEASED (Type or Print) <u>CHARLES G. WILLIAMS</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>April 10, 1970 1:45 P.</u> M.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
<u>928 S. Highland Ave. Baltimore, 21224, Md.</u>		A. STATE <u>Md.</u> B. COUNTY <u>2611</u>			
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>4-15-05</u> 9. AGE (In years last birthday) <u>64</u>	
<u>Retired</u>		<u>Pipe Cutter</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>David Williams</u>		14. MOTHER'S MAIDEN NAME <u>Annie ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>221-18-7547</u>		17. INFORMANT <u>Mrs. Mary A. Rykaczewski</u> ADDRESS <u>2040 Krimco Way Balto., 21222, Md.</u>	
18. <u>410.9 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE <u>Crowning Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Instant.</u>					
(B) <u>Anterior wall MI C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4-7</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-7</u> 19 <u>70</u> to <u>4-10</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4-7</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jason H. Gaskel</u> DEGREE				23B. DATE SIGNED <u>4-11-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>JASON H. GASKEL</u> DEGREE				23D. ADDRESS <u>637 S. Conkling St., Balto., 21224, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-13-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Sacred Heart Cemetery</u>	
24D. LOCATION (City, town, or county) <u>7401 German Hill Rd., Ba. Co., Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>APR 14 1970</u>			
24F. NAME OF REGISTRAR <u>Robert A. Gaskel</u>		24G. FUNERAL DIRECTOR <u>Charles S. Gaskel</u>		24H. ADDRESS <u>901 S. Conkling St. Balto., 21224, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

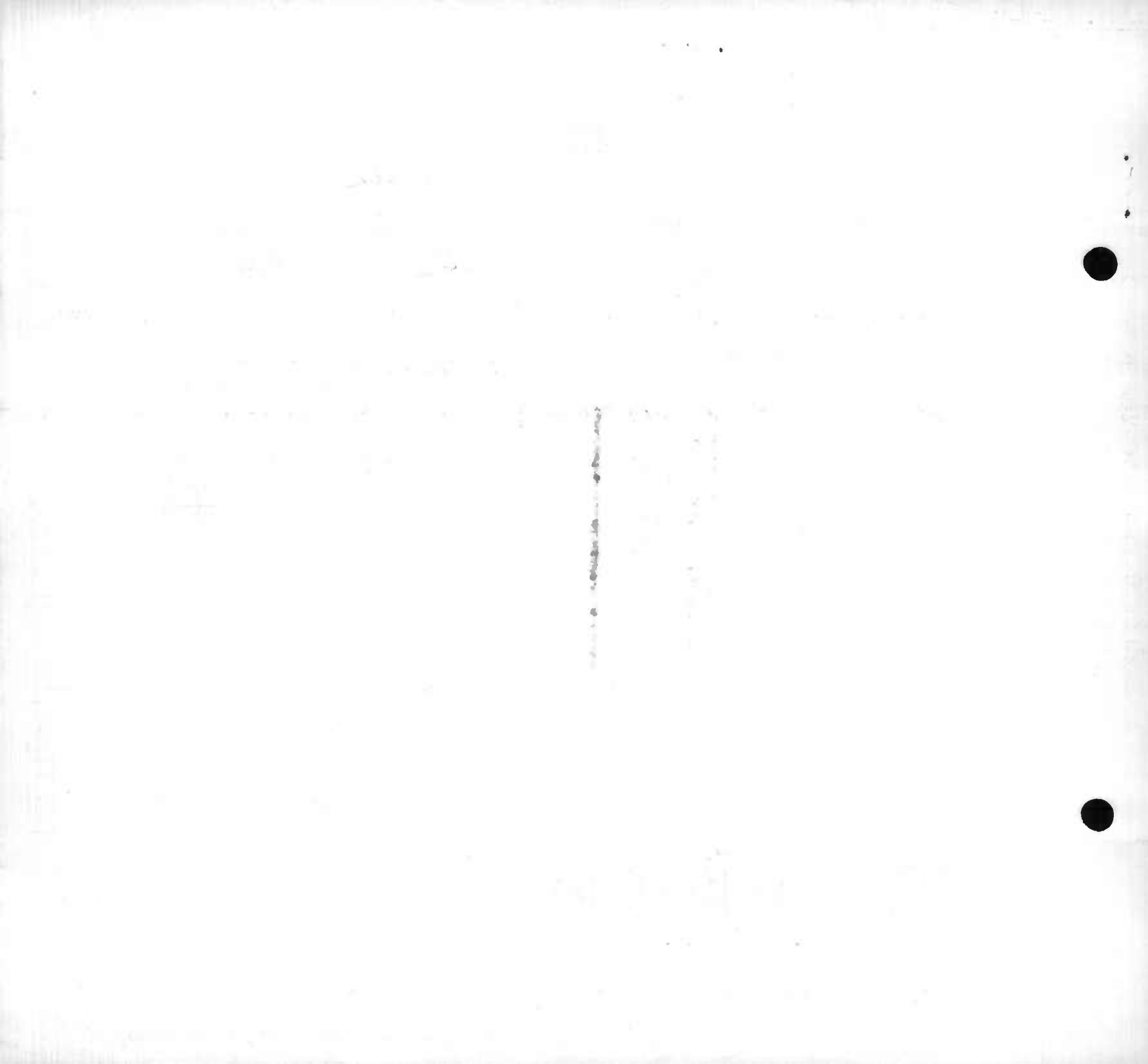
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3888	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) JAMES MARTINEK		2. DATE AND HOUR OF DEATH APRIL 9 1970 3:5PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hosp. 48			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Bradshaw Road		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/93	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10B. KIND OF BUSINESS OR INDUSTRY Produce Dealer		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Frank Martinek		
14. MOTHER'S MAIDEN NAME Barbara Fritche			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216-32-4566 A			17. INFORMANT 21021 ADDRESS Mrs Anna Hagy Bradshaw Rd. Bardshaw, Md.		
II					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH RESPIRATORY FAILURE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHRONIC BRONCHITIS & EMPHYSEMA (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (C) DUE TO, OR AS A CONSEQUENCE OF:					
19. DATE OF OPERATION 0					
20. AUTOPSY? (Yes or No) No					
21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
22. I certify that (I) (this hospital) attended the deceased from 3/20/70 19 to 4/9/70 19 that (I) (we) lost saw the deceased alive on 4/9/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Lamon Long MD					
23B. DATE SIGNED 4-9-70					
23C. PHYSICIAN'S NAME (Type) Lamon Long MD					
23D. ADDRESS Baltimore City Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 4-13-70					
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer					
24D. LOCATION (City, town, or county) (State) Baltimore City Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970					
25B. NAME OF REGISTRAR [Signature]					
25C. FUNERAL DIRECTOR [Signature]					
25D. ADDRESS 7401 Belair Rd.					



YS 150-REV. 1/1/68

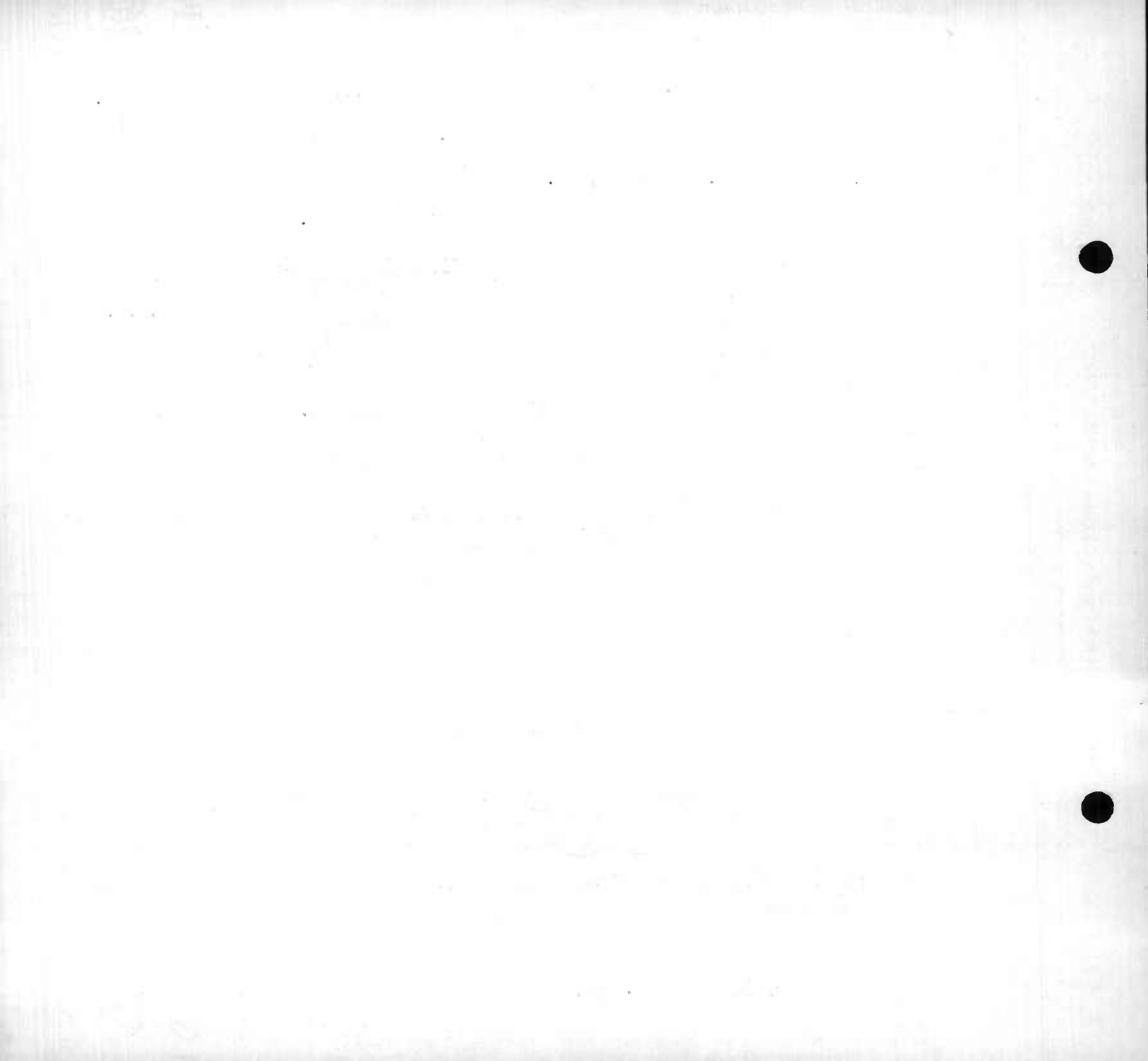
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3890	
BIRTH NO. S-530 70 3890				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) LUCRETIA H. SMITH			2. DATE AND HOUR OF DEATH 4/9/70 7 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1611 WEBSTER ST. BALTIMORE, MD. 00			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1611 WEBSTER ST.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/1895	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE DELASHMUTT			14. MOTHER'S MAIDEN NAME BAULGARDNER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 16 3112	17. INFORMANT CARROLL SMITH SR. ABOVE ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 4-12-70 I CORONARY INSUFFICIENCY ANTECEDENT CAUSES INTERMITTENT CARDIOVASCULAR DISEASE 2 months			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF (C) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 1966 to 4-9 1970, that (I) (we) last saw the deceased alive on 4-9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rolando V. Heno, MD DEGREE				23B. DATE SIGNED 4-10-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/13/70		24C. NAME of CEMETERY or CREMATORY MT. OLIVET	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. APR 14 1970		24F. NAME OF REGISTRAR J. E. Taylor, MD	
24G. FUNERAL DIRECTOR ADDRESS 1160 City 7/30 E. Fort Ave.					



70 3891 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 3891

BIRTH NO.

1. NAME OF DECEASED (Type or Print) J. W. MOORE JOHN W. MOORE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 10, 1970 5:15 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year April 10, 1970 5:15 p. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2572			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept. 26, 1920 49		E. STREET AND NUMBER 3111 Viona Ave. 21227	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U S	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Mary DeVine	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Mildred C. Moore		ADDRESS 3111 Viona Ave. 21227	
19. E 812.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Multiple traumatic injuries DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street.	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? On Patapsco Ave. E. of Rosalie Rd.		22F. HOW DID INJURY OCCUR? Subject driver in auto accident, struck a truck then a parked car.	
22D. TIME OF INJURY (APPROX.) 4 10 70 4 p. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 4/11/70 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/15/70	24C. NAME OF CEMETERY or CREMATORY Baltimore National	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25C. FUNERAL DIRECTOR M. E. Kelly ADDRESS 237 Patapsco Ave. 21225	

1988-07

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1988-07-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

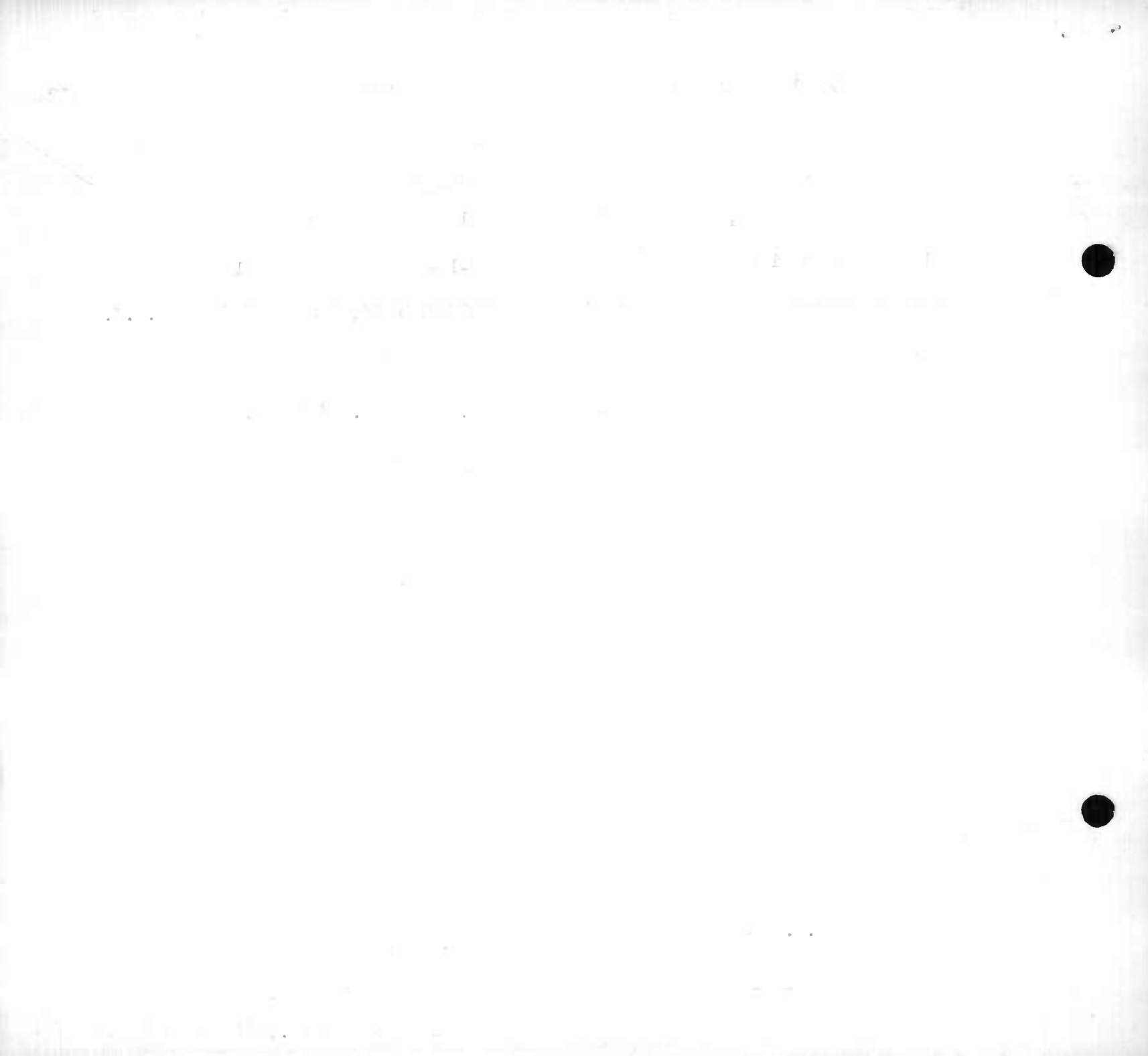
J-525 70 3892		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3892	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Johnson, James Eldridge		12 April 1970 1 20 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
University of Maryland Hospital 38		Maryland Baltimore 2544			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
M W		8. DATE OF BIRTH		9. AGE (in years last birthday)	
		1947 1907		63	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Bartender		BAR OWNER		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
William Johnson		Sarah Bell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-10-7301		Family - Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
192.9 I		Glioblastoma Multiforme		4 Mo	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
9 April 1970		PAIN		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 04 April 1970 to 12 April 1970 that (I) (we) last saw the deceased alive on 11 April 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Edward D. Lawrence MD				12 April 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Edward D. Lawrence MD					
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-16-70		Cedar Hill	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 14 1970		Robert E. Jones		237 Pat. Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

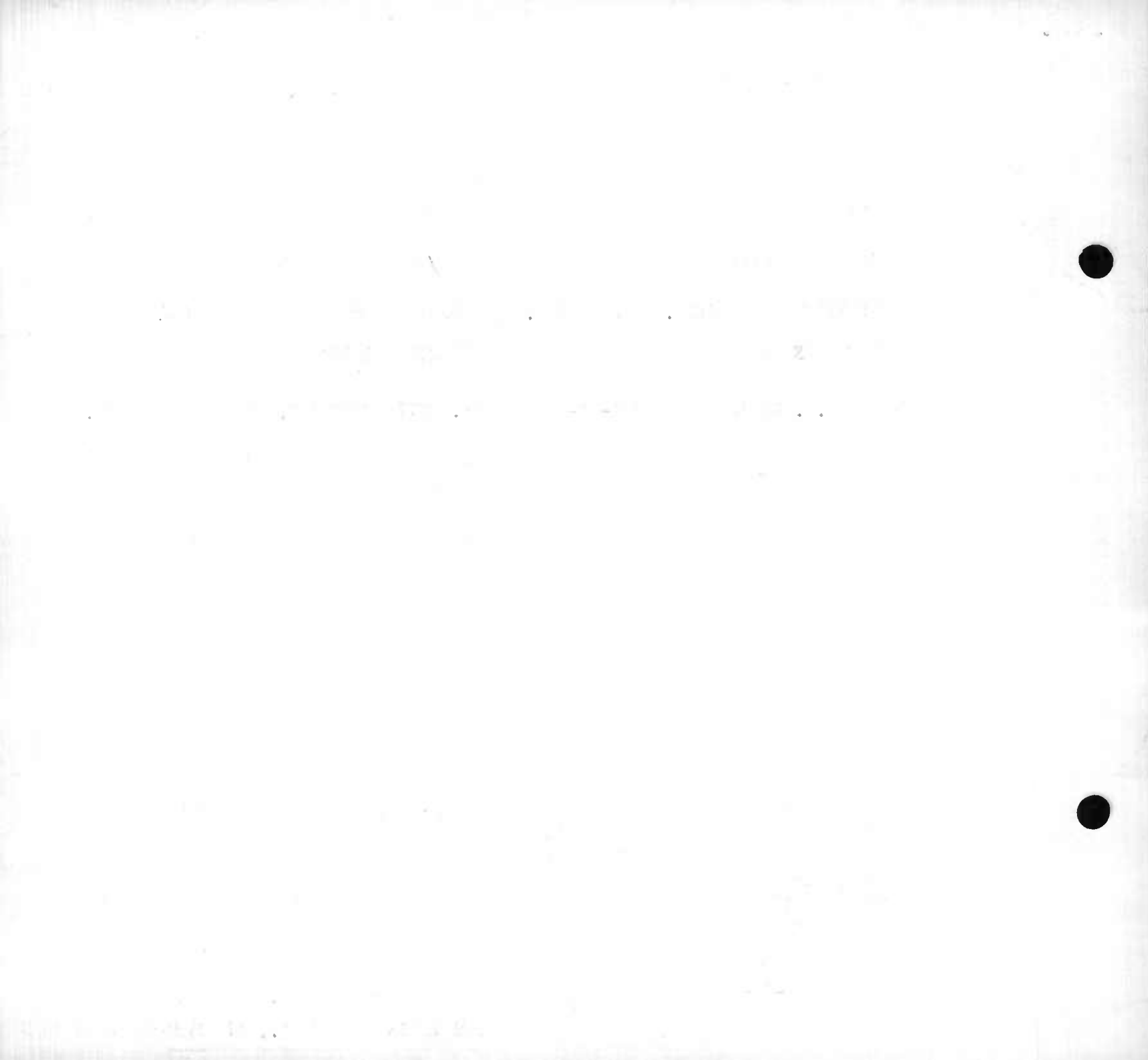
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>70 3893</u>	
BIRTH NO. <u>K-251</u>		70 3893		CERTIFICATE OF DEATH		REG. NO. 70 3893	
1. NAME OF DECEASED (Type or Print) <u>Charles - Kasinoff</u>				2. DATE AND HOUR OF DEATH <u>4-12-70</u> <u>5:22 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40</u> <u>ST. AGNES HOSPITAL</u> <u>CATON & WILKENS AVENUE</u> <u>BALTIMORE, MARYLAND 21229</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> <u>21208</u> <u>Balt Co.</u> <u>53-00</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>221 Sudbrook Lane</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-08</u>		9. AGE (in years last birthday) <u>61</u>	11. BIRTHPLACE (State or foreign country) <u>PHILADELPHIA, PENNSYLVANIA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME FINISHING</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HARRY KASINOFF</u>				14. MOTHER'S MAIDEN NAME <u>YETTA HACK</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-22-9030</u>		17. INFORMANT ADDRESS <u>MRS. BESSIE F. KASINOFF, 221 SUDBROOK LANE #8</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>acute Myocardial infarction</u> (B) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>A.S.C.V.D.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (indefinite medical opinion) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Am.</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>4-23-70</u> to <u>4-12-70</u> that (I) (we) last saw the deceased alive on <u>4-12-70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A. S. NAMSI M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-12-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>A.S. NAMSI</u>		23D. ADDRESS <u>ST. AGNES HOSPITAL</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-13-70</u>		24C. NAME of CEMETERY or CREMATORY <u>OHEB SHALOM</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

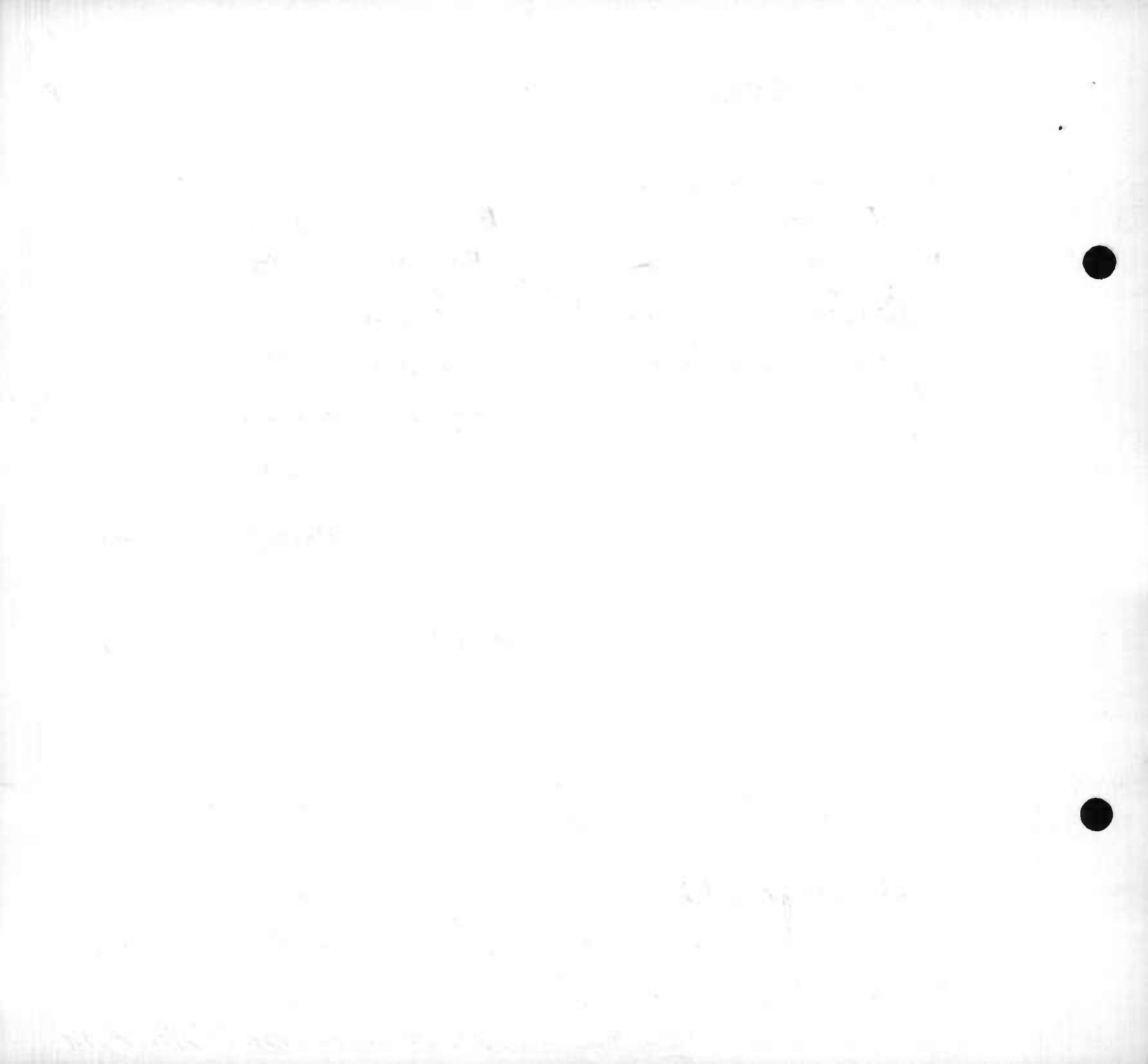
P-623 70 3894		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3894	
1. NAME OF DECEASED (Type or Print) GEORGE PRISTOOP		2. DATE AND HOUR OF DEATH APRIL 12, 1970 16.03 Ann.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6730 Brompton Rd #07			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/15/08	9. AGE (In years last birthday) 61
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT CUTTER		10B. KIND OF BUSINESS OR INDUSTRY BALTO. MARKETS INC.		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME ABRAHAM PRISTOOP		14. MOTHER'S MAIDEN NAME FANNIE MOLOFSKY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY		16. SOCIAL SECURITY NO. 217-01-3293		17. INFORMANT ADDRESS MRS. BETTY PRISTOOP, 6730 BROMPTON RD. #7	
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/12/70 to 4/12/70 that (I) (we) last saw the deceased alive on 4/12/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Graynor md.		23B. DATE SIGNED 4/12/70		23C. PHYSICIAN'S NAME (Type) GRAYNOR	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-13-70		24C. NAME OF CEMETERY or CREMATORY MOSES MONTIFIOR	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 14 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-455 70 3895				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3895	
1. NAME OF DECEASED (Type or Print) JACOB WALMAN WALMAN				2. DATE AND HOUR OF DEATH 4/10 11 30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Levin Dale Hobson Home and 91 E. FARMWAY				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD B. COUNTY 2717 C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Belvedere and Greenspring			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/1884	9. AGE (In years last birthday) 85	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dealer			10B. KIND OF BUSINESS OR INDUSTRY Scrap metal		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Hyman Walman			14. MOTHER'S MAIDEN NAME Sarah				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Joseph Walman 222 St Paul St		ADDRESS
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: years				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). pneumonitis						Days	
19A. DATE OF OPERATION 4/10/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/12/7 19 68 to 4/10 19 70 that (I) (we) last saw the deceased alive on 4/10 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ellis S. Caplan MD				23B. DATE SIGNED 4/10/70		23C. PHYSICIAN'S NAME (Type) ELLIS S. CAPLAN	
23D. ADDRESS Levin Dale Hobson Home				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/12/70		Bnai Israel Cong		Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR John J. Brown		ADDRESS 608 Rust Rd.	



FUNERAL DIRECTOR: IMPORTANT

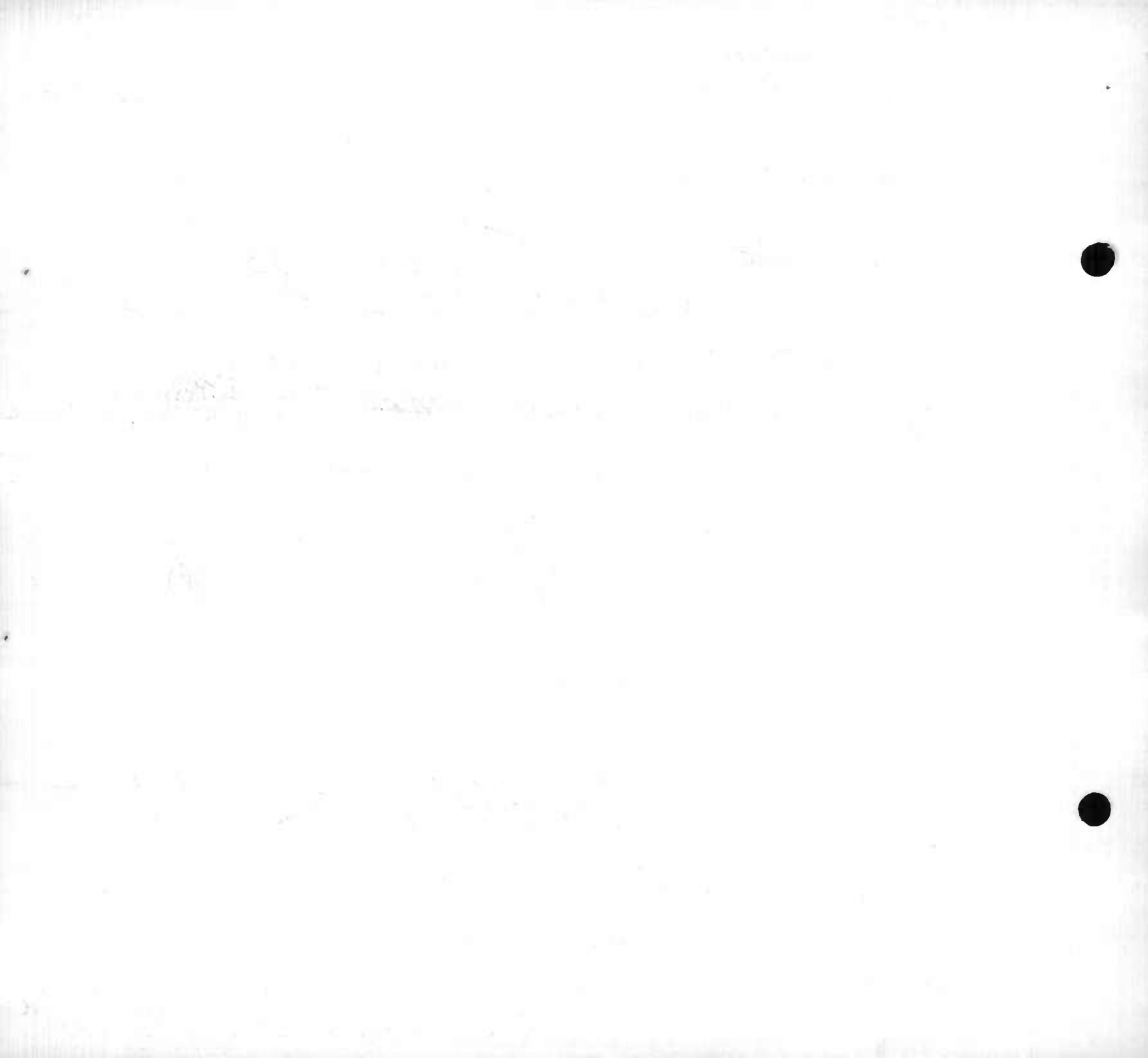
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3896	
1. NAME OF DECEASED (Type or Print) HOWARD GELBLUM		2. DATE AND HOUR OF DEATH APRIL 12, 1970 7:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3932 W. NORTHERN PKWY., APT. C-1		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2719 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3932 W. NORTHERN PKWY., APT. C-1	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 25, 1902
9. AGE (In years last birthday) 68		If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN
10B. KIND OF BUSINESS OR INDUSTRY INSURANCE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL GELBLUM	
14. MOTHER'S MAIDEN NAME SARAH LAPPIN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 552-07-1807		17. INFORMANT MRS. YETTA GELBLUM, 3932 W. NORTHERN PKWY. APT. C-1	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Stomach (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(B) DUE TO, OR AS A CONSEQUENCE OF: _____ (C) DUE TO, OR AS A CONSEQUENCE OF: _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1967 19 to 1970 19 that (I) (we) last saw the deceased alive on 4/4/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Milton Kirsh		23B. DATE SIGNED 4/13/70	
23C. PHYSICIAN'S NAME (Type) MILTON KIRSH		23D. ADDRESS 4000 W. NORTHERN PKWY	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-13-70	
24C. NAME OF CEMETERY or CREMATORY CHIZUK AMUNO		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

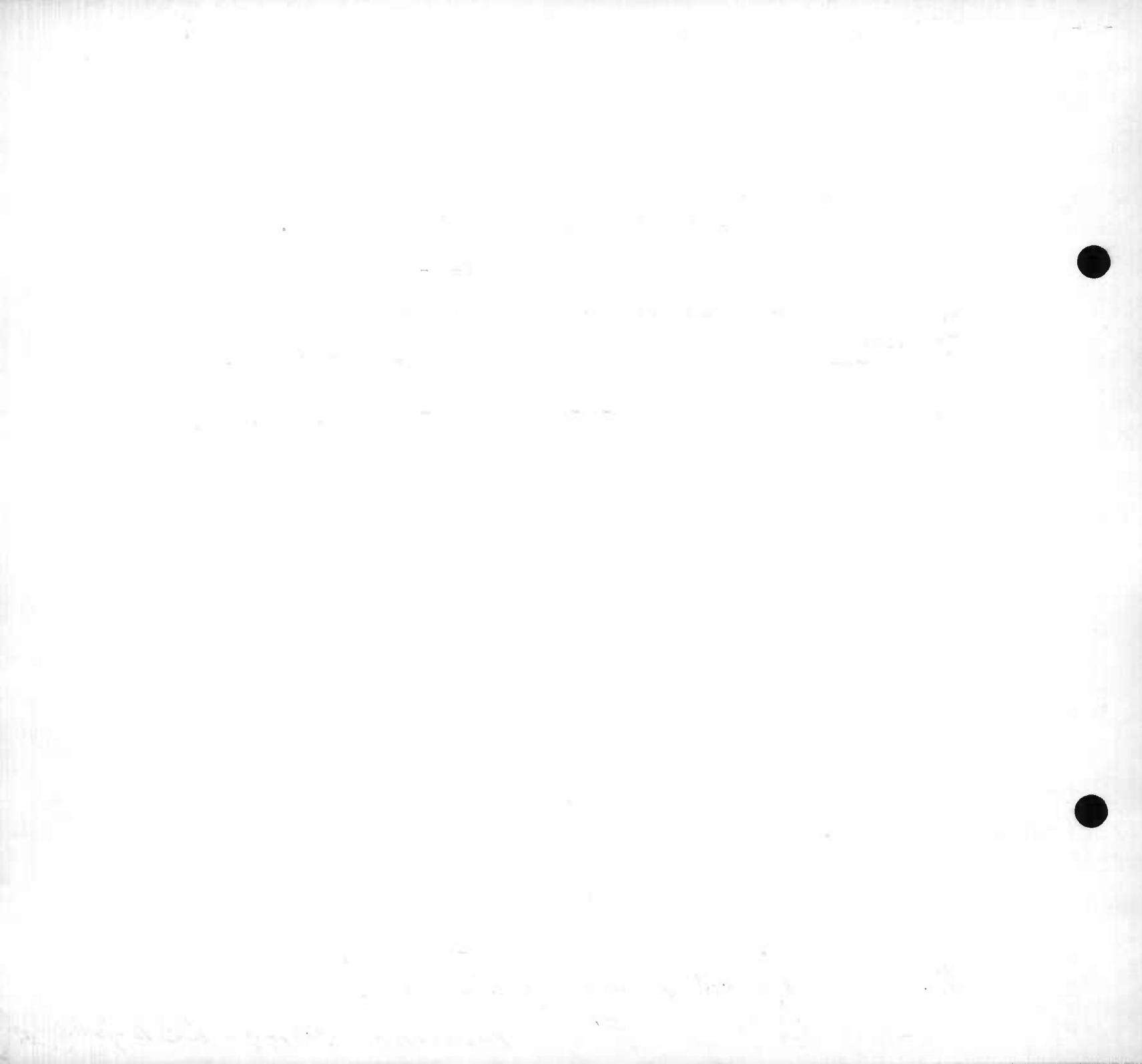
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-536 70 3897				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3897	
BIRTH NO. (1313131)				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LOUIS HANDWERGER				2. DATE AND HOUR OF DEATH 4/11/70 11:07 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2831			
FULL NAME OF HOSPITAL OR INSTITUTION Simon Hospital 42		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/25/96	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY Race Track		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Handwerker				14. MOTHER'S MAIDEN NAME Rebecca Weinberg			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I - ARMY 215-16-2900				16. SOCIAL SECURITY NO. 5-11-11-11		17. INFORMANT Mrs. Sara Bergeron 4109 W. Rogers Avenue	
18. 1541 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. If means the disease, injury or complication which caused death.) Possible pulmonary embolus minutes ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Postop for Carcinoma of rectum months Myocardial infarction (old) 3 months				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 4/6/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cc rectum		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/11/70 19 20 to 4/11/70 19 20 and that (I) (we) last saw the deceased alive on 4/11/70 19 20 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Marvin Nachlas				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/11/70	
23C. PHYSICIAN'S NAME (Type) MARVIN M. NACHLAS				23D. ADDRESS LATROBE BUILDING			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE APR 12/70		24C. NAME OF CEMETERY OR CREMATORY JEWISH WAR VETERANS		24D. LOCATION (City, town, or county) (State) Rosedale, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR John E. [Signature]		25C. FUNERAL DIRECTOR Sol [Signature]		25D. ADDRESS 6010 [Address]	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		70 3898		CITY HEALTH DEPARTMENT		REG. NO. 70 3898	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
Mildred Ann Smith				2. DATE AND HOUR OF DEATH 4/12/70 4:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1606			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Female 6. RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 12-14-02 9. AGE (In years lost birthday) 67			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10B. KIND OF BUSINESS OR INDUSTRY 47 Home				11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME L. HAM John Davis				14. MOTHER'S MAIDEN NAME Missie HARRIET HARRIS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO				16. SOCIAL SECURITY NO. 218-05-5736 17. INFORMANT BCH-Records ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224			
18. 200.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute GI bleeding (B) Reticulum cell sarcoma (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hr 4 yrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 4/12/70 19 to 4/12 19 70 that (1) (we) last saw the deceased alive on 4/12 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David J. Riley MD DEGREE				23B. DATE SIGNED 4/12/70			
23C. PHYSICIAN'S NAME (Type) David J. Riley, MD DEGREE				23D. ADDRESS 4940 Eastern Avenue BCH- Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/16/70 24C. NAME OF CEMETERY OR CREMATORY ARBUTUS PARK ARBUTUS - BALTIMORE 21224			
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970				25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR Mansfield Phylis 6380 Gethers Rd			



B-625

70

3899

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3899

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ARTHUR BRYSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 537 N. Mount St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 13 1970 6:30 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 4-9-1916		10. AGE (In years last birthday) 54	
11. BIRTHPLACE (State or foreign country) SPARTANSBURG SC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FOLTON BRYSON		14. MOTHER'S MAIDEN NAME BLANCH FERGUSON	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONGSHORN MAN PORT 7 BALTO		16. KIND OF BUSINESS OR INDUSTRY PORT 7 BALTO	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		18. SOCIAL SECURITY NO. 2-48-10-5839	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of the liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 4/16/70	
24C. NAME OF CEMETERY or CREMATORY Family Plot		24D. LOCATION (City, town, or county) (State) SPARTANSBURG S.C.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Markham Phillips		ADDRESS 638 N. Gilman St.	

ACADEMY BOND

WILSON COUNTY

WILSON COUNTY

18

L-365

70 3900 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3900

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HOMER LOUDERMILK		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 12 1970 7:26 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE City Hospitals		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 12 1970 7:26 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Oct. 15, 1905		10. AGE (in years last birthday) 64	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY Steelworker	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 409-10-8463	
15. MOTHER'S MAIDEN NAME Hattie Monday		18. INFORMANT J.D. Loudermilk	
19. E 950.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute barbiturates and ethenol poisoning		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 4-12-70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3404 E. Lombard St. 2608		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) 4-12-70 ?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Ingested overdose of barbiturates.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/16/70	
24C. NAME OF CEMETERY or CREMATORY Wolf Creek Cemetery		24D. LOCATION (City, town, or county) (State) Cherokee County, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Lilly & Zeiler, Inc.	
25C. FUNERAL DIRECTOR Lilly & Zeiler, Inc.		ADDRESS 1901 Eastern Ave. Balto., Md. 21231	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3901	
8-300 70 3901 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Thelma Scott		2. DATE AND HOUR OF DEATH 4/13/70 2:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 8. COUNTY 402			
FULL NAME OF HOSPITAL OR INSTITUTION Waf Md. Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 653 W. Mulberry St.			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/18	9. AGE (In years lost birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hus		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Smithfield Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME John K?		14. MOTHER'S MAIDEN NAME Emma Crocker	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Husband ADDRESS	
18. 519.2 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest		20 mins.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Bronchial Spasm DUE TO, OR AS A CONSEQUENCE OF:			
(C) Chronic Pulmonary Disease				years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that to (this hospital) attended the deceased from 19 70 to 4/13 1970 , that to (we) last saw the deceased alive on 4/13 1970 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. by (We) (did) not view the body after death.					
23A. SIGNATURE Daniel J. Freedenburg, Jr. M.D.				23B. DATE SIGNED 4/13/70	
23C. PHYSICIAN'S NAME (Type) Daniel J. Freedenburg, Jr. M.D.				23D. ADDRESS 1921 Greenberry Rd Balto., Md.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 4/17/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Balto. Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR R. E. E.	
25C. FUNERAL DIRECTOR Williams Funeral Home		25D. ADDRESS 319 N. Sepulchre St.			

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Prof. Dr. H. H. H.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO.	
M-600 70 3902		70 3902		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ELIAS MOORE		4-12-70 10:10 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		A. STATE Md.		B. COUNTY 1002	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 937 Abbott Ct.			
5. SEX M	6. RACE N N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-86	9. AGE (in years last birthday) 83	10. If Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Greenville, N. C.	
13. FATHER'S NAME John Moore		14. MOTHER'S MAIDEN NAME Martha		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-1861		17. INFORMANT ADDRESS Martha Ann Thornton - 937 Abbott Court	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE CVA DUE TO, OR AS A CONSEQUENCE OF: (B) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one day year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4/11 1970 to 4/12 1970 that (we) last saw the deceased alive on 4/12 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE Barbedo M.D.		23B. DATE SIGNED 4/12/70		23C. PHYSICIAN'S NAME (Type) BARBEDO M.D.	
23D. ADDRESS MERCY HOSP.		23E. DATE REC'D BY HEALTH DEPT. APR 14 1970		23F. NAME OF REGISTRAR Robert E. Farber, M.D.	
23G. FUNERAL DIRECTOR Charles R. Law		23H. ADDRESS 802 Madison Ave.		23I. DATE REC'D BY HEALTH DEPT. APR 14 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-70		24C. NAME OF CEMETERY OR CREMATORY Carver Memorial Park	
24D. LOCATION Laurel, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 14 1970		24F. NAME OF REGISTRAR Robert E. Farber, M.D.	
24G. FUNERAL DIRECTOR Charles R. Law		24H. ADDRESS 802 Madison Ave.		24I. DATE REC'D BY HEALTH DEPT. APR 14 1970	

Q. 1.

What is the name of the person who is the subject of the report?

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3903

BIRTH NO.

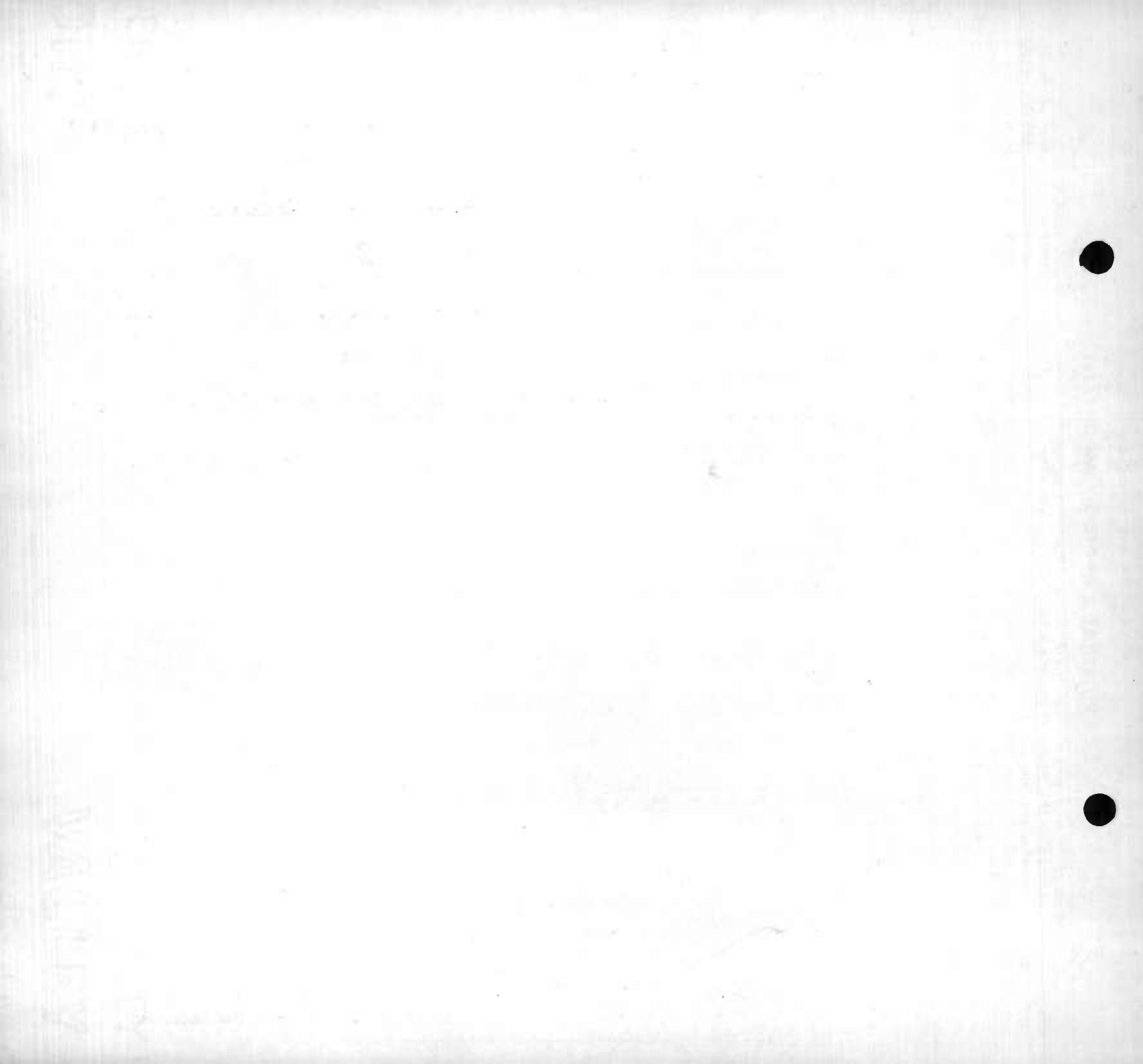
1. NAME OF DECEASED (Type or Print) PHILLIP RICH, Jr.				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 4 10 70 9:30 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital				3. DATE PRONOUNCED DEAD Month Day Year April 10, 1970 9:30 p.m.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3-17-28				10. AGE (in years last birthday) 42		11. BIRTHPLACE (State or foreign country) Warsaw, Virginia	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME Alex Rich		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Pauline Jackson				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II		17. SOCIAL SECURITY NO. 229-20-5285	
18. INFORMANT Edward Rich - 904 N. Monroe St.				19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) YES				22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 500 blk. Pressman St. 14-03			
22D. TIME OF INJURY (APPROX.) 4 4 70 4:20				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Subject approached by 2 men, and was shot				23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
24. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4-15-70			
24C. NAME OF CEMETERY or CREMATORY Baltimore National				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR Charles R. Law				ADDRESS 802 Madison Ave.			

580 Pressman St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3904	
BIRTH NO. 70 3904		70 3904		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>EL, T. Barber</i> (Elthomas Barber)			2. DATE AND HOUR OF DEATH <i>4-9-70</i> <i>11.45 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1608</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hosp. of Md.</i> <i>46</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>914 Poplar Grove St.</i>		
5. SEX <i>Male</i>	6. RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-1-08</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Handy Man</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Rockhill, S. C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>John Barber</i>		
14. MOTHER'S MAIDEN NAME <i>Carrie Barber</i>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>579-05-7198</i>			17. INFORMANT <i>Carrie Alexander - 2327 W. Mosher St.</i>		
18. <i>431.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Hemorrhage</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 hours</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>no operation</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-8-70</i> 19 <i>70</i> to <i>4-9</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>4-9</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Behnaz Jalali</i>				23B. DATE SIGNED <i>4-9-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Behnaz Jalali</i>				23D. ADDRESS <i>Lutheran Hosp. of Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-13-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. FUNERAL DIRECTOR <i>Charles R. Law</i> 802 Madison Ave.			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 14 1970</i>		25B. NAME OF REGISTRAR <i>Jalali</i>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3905

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN H. MATTESON

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

April 8, 1970

2:30 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FATHER'S NAME (Type or Print) ADDRESS OR LOCATION

33 John Hopkins Hospital

4-15-70

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 8, 1970

2:30 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore 5300

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

5-12-1906

10. AGE (in years)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

6739 Bessemer Avenue

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MECHANIC

14B. KIND OF BUSINESS OR INDUSTRY

EXTERMINATOR

15. MOTHER'S MAIDEN NAME

MABLE -

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Emma M. Matteson - 6739 BESSEMER AVE.

19.

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CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic-vascular-disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 9, 1970

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/13/70

24C. NAME OF CEMETERY or CREMATORY

OAK LAWN CEMETERY

24D. LOCATION (City, town, or county)

BALTO., MD.

25A. DATE REC'D BY HEALTH DEPT.

APR 14 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Hartley, Biddle - 2334 Jefferson St

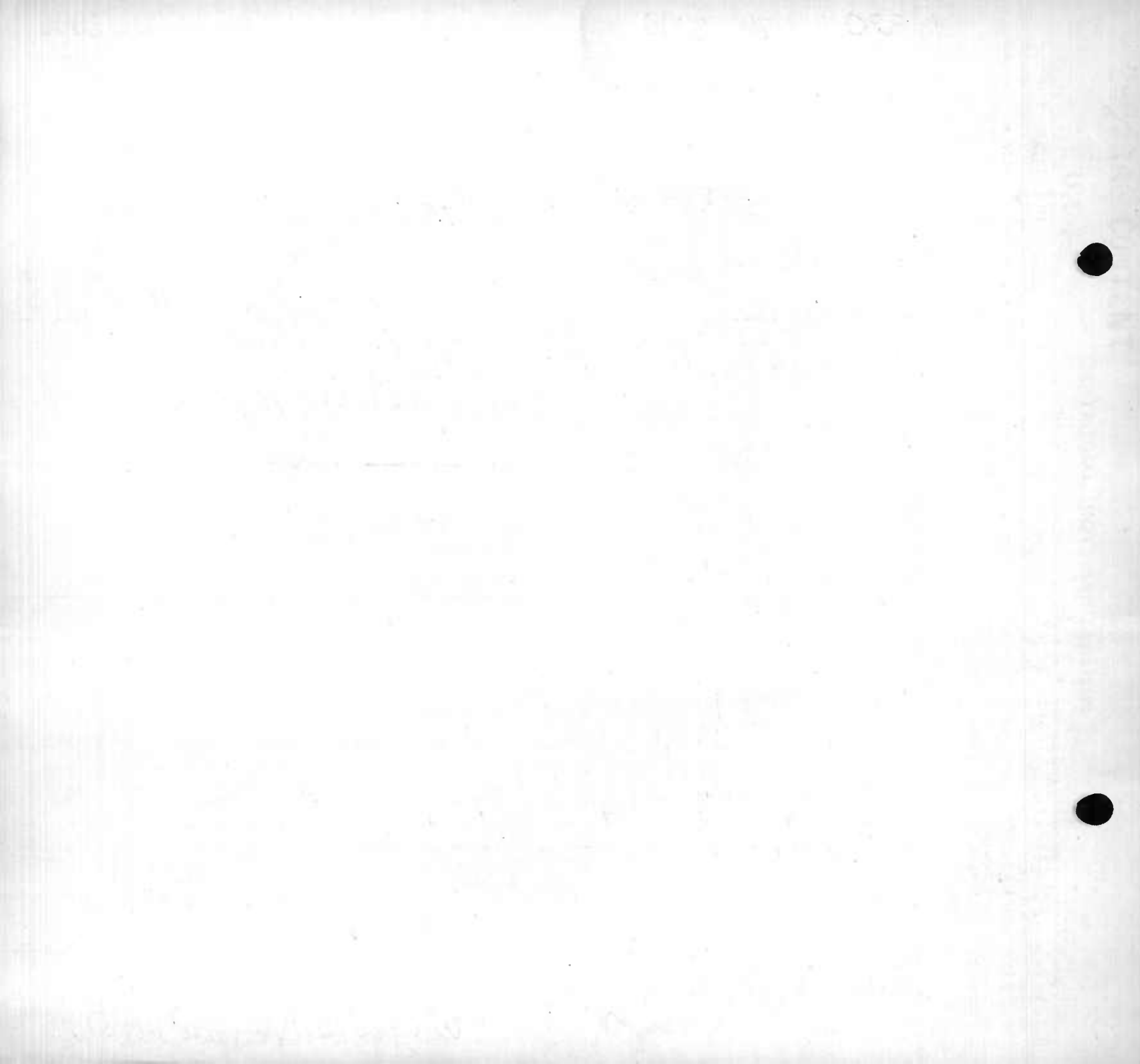
Letter from M.E.'s office

4-15-70

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

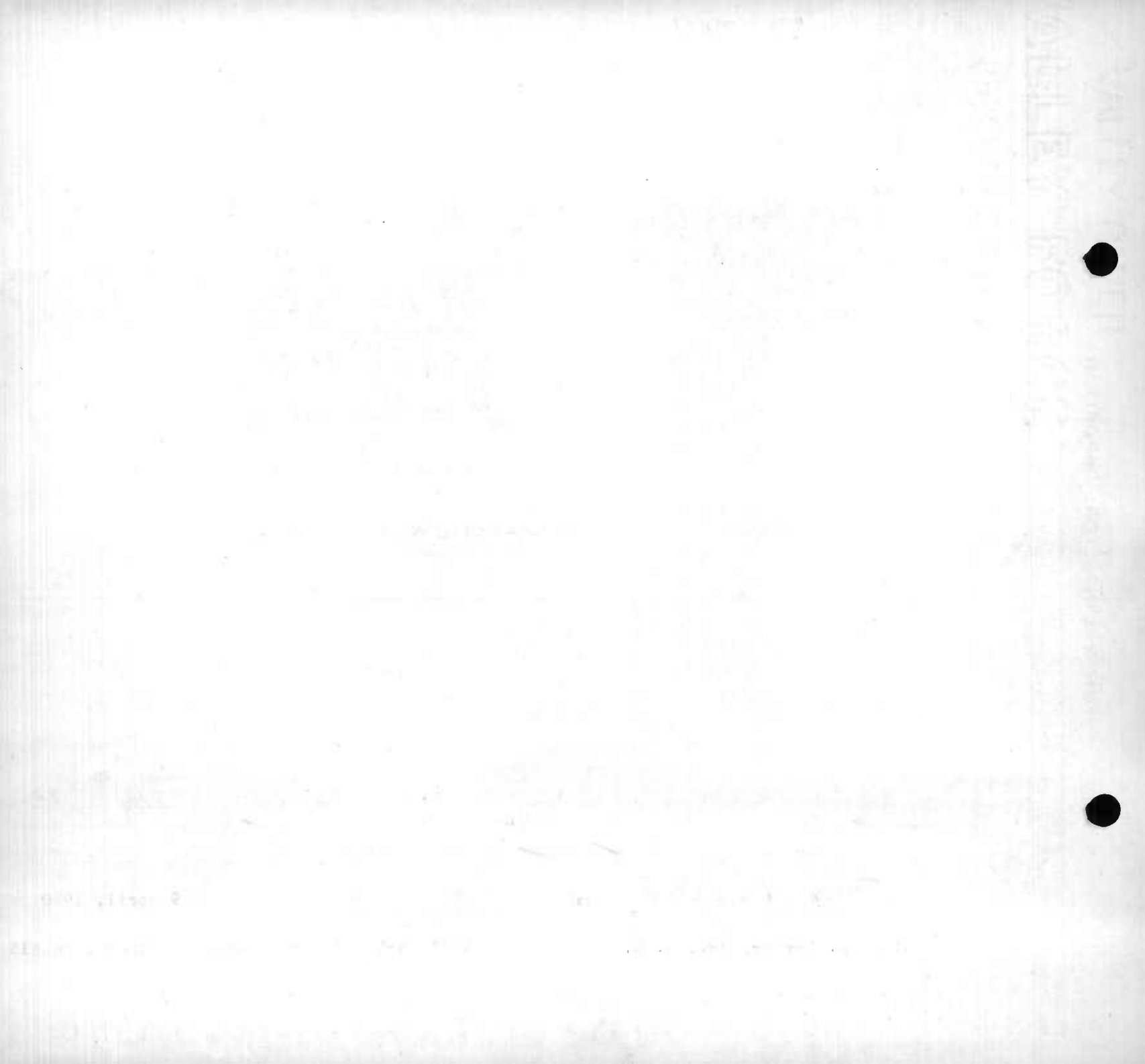
T-520		70 3906		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3906	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) <i>Nettie Thomas</i>				2. DATE AND HOUR OF DEATH <i>April 9, 1970 12:30 P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>1501</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 House of Pine 25205 Benedict</i>				C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1527 N. Strucker St</i>							
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday) <i>80 yrs</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>St. Mary's</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>				13. FATHER'S NAME <i>Morgan</i>			
14. MOTHER'S MAIDEN NAME <i>Nettie Hicks</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <i>220-30-0124</i>				17. INFORMANT <i>Jane Holly</i>			
18. <i>2509 I</i> CAUSE OF DEATH				ADDRESS <i>1527 N. Strucker St</i>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Probable Pulmonary Embolus</i> <i>15 minutes</i>			
				(B) <i>Cerebral Thrombosis</i> <i>2 weeks</i>			
				(C) <i>Diabetes Mellitus</i> <i>5 yrs</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>March 9, 1970</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Amputation (mid thigh) of RIGHT</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/31</i> 1970 to <i>4/9</i> 1970, that (I) (we) last saw the deceased alive on <i>4/5</i> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.							
23A. SIGNATURE <i>Alan B. Cohen</i>				23B. DATE SIGNED <i>4/10/70</i>			
23C. PHYSICIAN'S NAME (Type) <i>Alan B. Cohen</i>				23D. ADDRESS <i>3501 ST Paul ST Balto Md 21218</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>4/13/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 14 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Virgie B. Ringgold</i>		ADDRESS <i>1463 N. Carey St</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

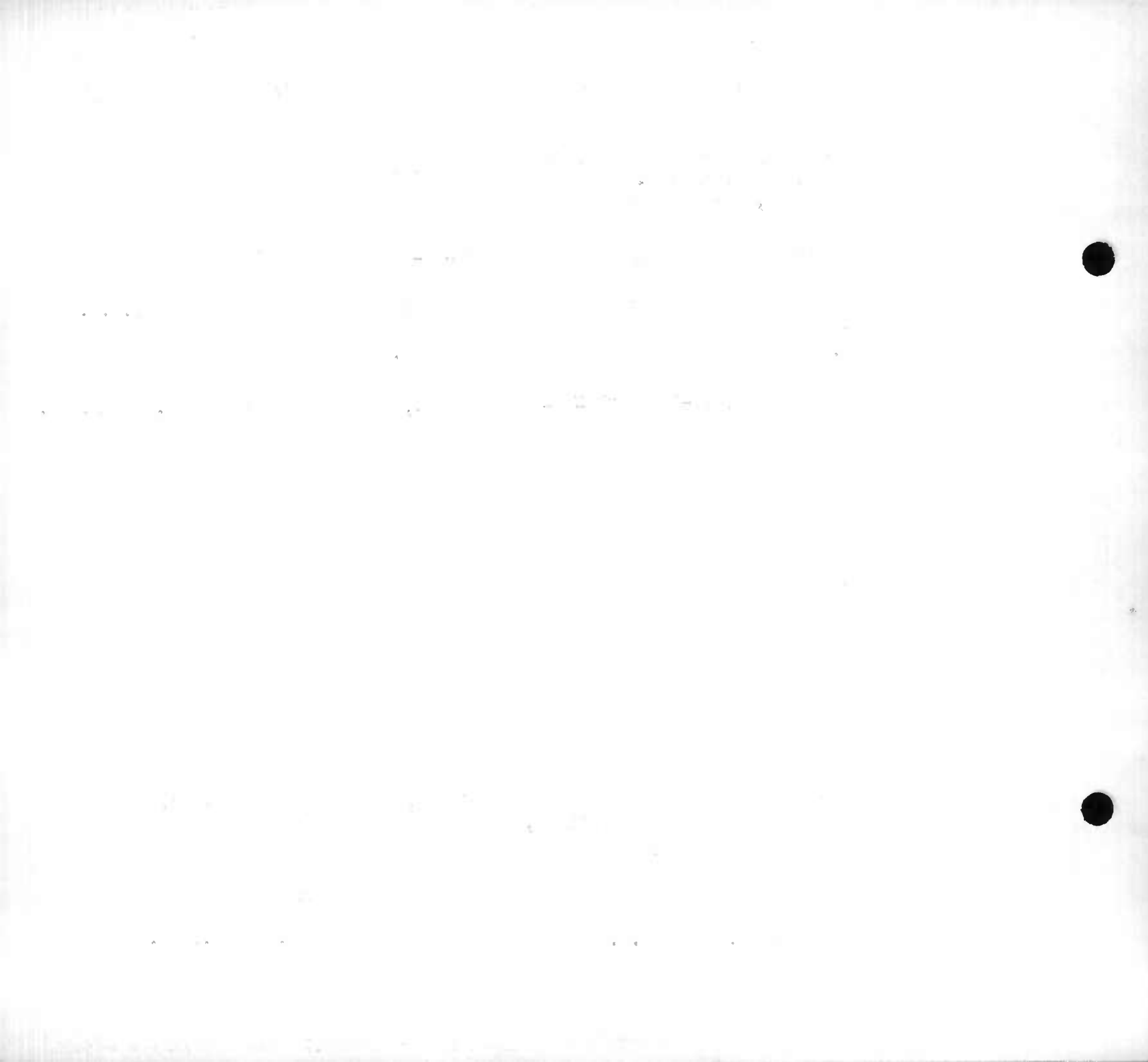
W-300 70 3907		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3907	
1. NAME OF DECEASED (Type or Print) <i>Ida Nettie J. Thomas White</i>		2. DATE AND HOUR OF DEATH <i>4-8-70 - 1030</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1513</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>House in the Pine's 202615 Quantic Ave</i>		C. CITY OR TOWN <i>Balto-</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i> 6. RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>70</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>St Mary's Co.</i>	
13. FATHER'S NAME <i>Willie Mason</i>		14. MOTHER'S MAIDEN NAME <i>Ida Mason</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Worothy Murray</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis C & D</i> (C) _____		ADDRESS <i>3351 Woodland</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>10 years</i>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Apr 1st</i> to <i>8 Apr</i> 1970, that (I) <i>last</i> saw the deceased alive on <i>Mar 1970</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>did not</i> (did) view the body after death.					
23A. SIGNATURE <i>Simon H. Carter</i>				23B. DATE SIGNED <i>9 April, 1970</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
<i>Simon H. Carter, Jr., M.D.</i>		<i>4215 Park Heights Avenue, Baltimore, Md #15</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<i>Burial</i>		<i>4/11/70</i>		<i>New Cathedral</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<i>APR 14 1970</i>		<i>Robert E. Taber, M.D.</i>		<i>U. Brooks Riggold</i>	
				ADDRESS <i>14637, Carey</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-500		70 3908		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3908	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				MANN, JOHN MEREDITH		2. DATE AND HOUR OF DEATH April 11, 1970 7:30 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218				Maryland			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5318 Holder Avenue			
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-11-98	
						9. AGE (in years last birthday) 71	
						10. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry P. Mann				14. MOTHER'S MAIDEN NAME Helen E. Chester			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 3-20-17 to 7-19-19				16. SOCIAL SECURITY NO. 216-85-99-91A		17. INFORMANT Records	
				ADDRESS VA Hosp., B900 Loch Raven Blvd. Balto, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 284V I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANAEMIA (B) APLASTIC ANAEMIA DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months "	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, room, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from April 11, 1970 to April 11, 1970 that (X) (we) last saw the deceased alive on April 11, 1970 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 4. 11. 70			
23C. PHYSICIAN'S NAME (Type) Sayed T. Shah M.D.				23D. ADDRESS 3900 Loch Raven Blvd. Balto., Md. 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/15/70		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Towson Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Theobald J. Cook		ADDRESS 7700 Harford Rd	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		70 3909		REG. NO. 70 3909	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Stewart Jaymes T. MRS.</i>		2. DATE AND HOUR OF DEATH <i>4-9-70 8:30 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>34 Bon Secours Hosp.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1901</i>		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hosp.</i>		E. STREET AND NUMBER <i>1512 Vine St.</i>			
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>07/29/15</i>	9. AGE (in years last birthday) <i>54</i>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>George Hammond</i>		14. MOTHER'S MAIDEN NAME <i>Florence Dorsey</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Chart</i>	
18. <i>250.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Severe fibrinous pericarditis</i> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Diabetes mellitus & K W disease year</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Severe fibrinous pericarditis</i> (B) <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Diabetes mellitus & K W disease year</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4-6 weeks</i> <i>4-6 weeks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>X</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <i>In Baltimore City, give exact location</i>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (this hospital) attended the deceased from <i>3-6</i> 19 <i>70</i> to <i>4-9</i> 19 <i>70</i> that (I) <i>(we)</i> last saw the deceased alive on <i>4-4-70</i> 19 <i>70</i> and that (in my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> (did) <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>Iain C. Kerr MB ChB</i>		23B. DATE SIGNED <i>4-9-70</i>		23C. PHYSICIAN'S NAME (Type) <i>Iain C. Kerr MB ChB</i>	
23D. ADDRESS <i>BON SECOURS HOSP. BALTO #23</i>		23E. PHYSICIAN'S DEGREE <i>DEGREE</i>		23F. PHYSICIAN'S SPECIALTY <i>DEGREE</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/15/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT Auburn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>		24E. DATE REC'D BY HEALTH DEPT. <i>APR 14 1970</i>		24F. NAME OF REGISTRAR <i>Robert E. Taylor, R.D.</i>	
24G. FUNERAL DIRECTOR <i>Adolphus Halstead</i>		24H. ADDRESS <i>1206 W north Ave</i>		24I. DATE OF DEATH <i>4-9-70</i>	

THE JEFFERSON MEMORIAL
WASHINGTON, D.C.
JAN 19 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3910				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3910			
1. NAME OF DECEASED (Type or Print) JOHN MARSHALL				2. DATE AND HOUR OF DEATH April 11-1970 11:15P.				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 807							
FULL NAME OF HOSPITAL OR INSTITUTION 90 Mt. Sinai Nursing Home				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 2022 Clewelyn ave											
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-94		9. AGE (In years last birthday) 75		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Marshall				14. MOTHER'S MAIDEN NAME Susan Skalter							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 2-12-18-4003		17. INFORMANT Julia Marshall				ADDRESS 2022 Clewelyn Ave.	
18. 150X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of oesophagus with Metastases				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 3-14-70				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Proctectomy				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 25 19 70 to April 11 19 70 , that (I) (we) last saw the deceased alive on April 10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE Louis T. Lavy				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 4-11-70			
23C. PHYSICIAN'S NAME (Type) LOUIS T. LAVY M.D.				23D. ADDRESS 3502 W. Rogers Ave							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/15/70		24C. NAME OF CEMETERY or CREMATORY Landon National Cem.		24D. LOCATION (City, town, or county) (State) Balti. Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR R. E. Taylor, M.D.				25C. FUNERAL DIRECTOR Chas. J. Jones			
								ADDRESS 1129 N. Charles St.			

APR 14 1970

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES JOYNER

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

4

11

70

7:44 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital D.O.A.

3. DATE PRONOUNCED DEAD

April 11, 1970

744 4pm.

5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)

A. STATE

B. COUNTY

Maryland

808

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

April 18, 1911

10. AGE (In years lost birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1010 Lamont Ave.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

unknown

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

15. KIND OF BUSINESS OR INDUSTRY

13. MOTHER'S MAIDEN NAME

unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Hannie Jones 1228 N. Broadway

19.

E81471

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
Street

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

S. Broadway 26' S. of Eager

808

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

4

11

70

7:30

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/12/70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/16/70

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Westport, Md.

(State)

25A. DATE RECEIVED BY HEALTH DEPT.

APR 14 1970

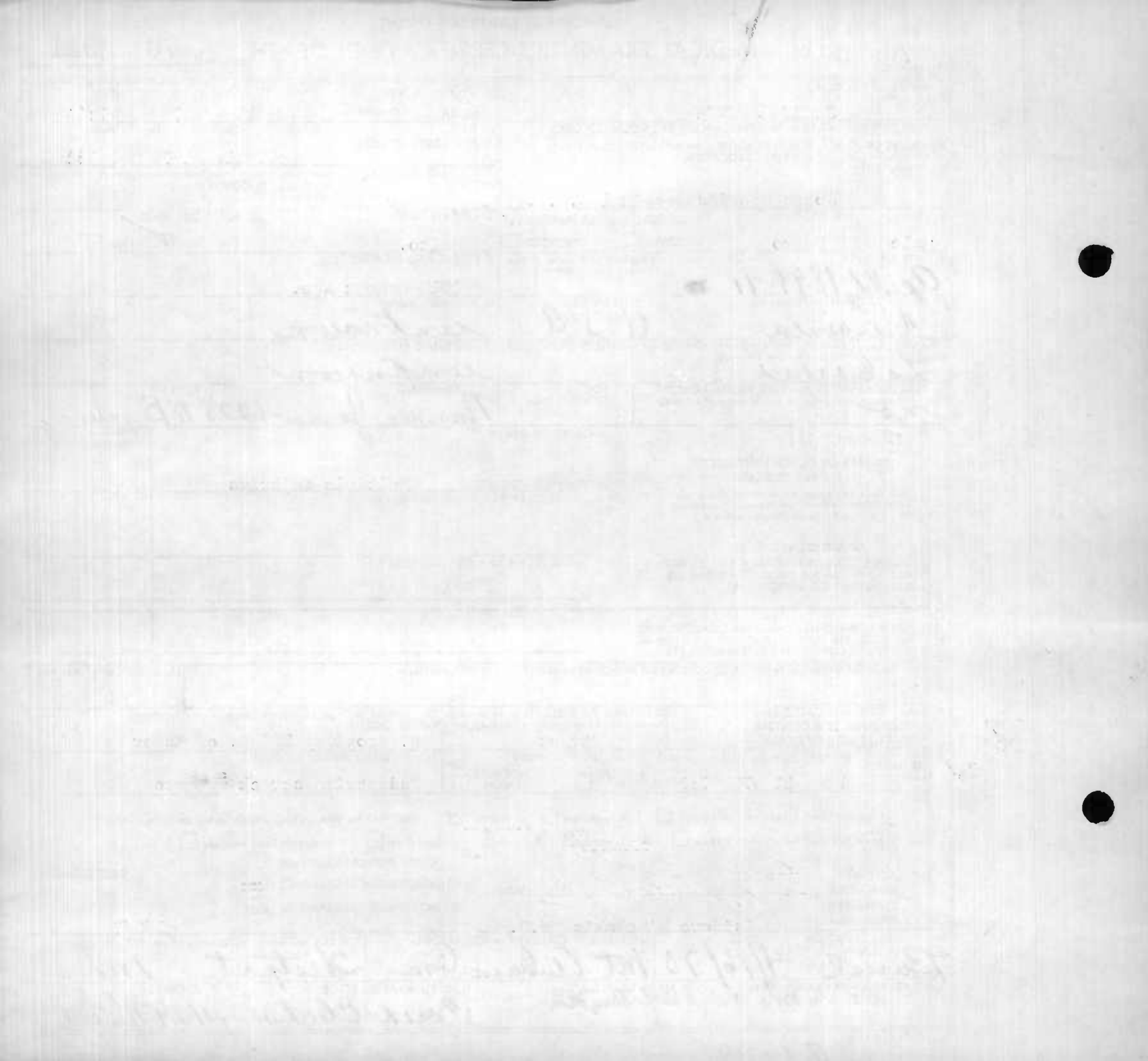
25B. NAME OF REGISTRAR

Robert E. Taylor, R.D.

25C. FUNERAL DIRECTOR

Zoea Eickson - 1129 N. Caroline

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Vance Simpson</i>		2. DATE AND HOUR OF DEATH <i>4-13-70</i> <i>12:25 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>806</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bolton Hill Wrsg Home</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>1712 N. Wolfe St.</i>	
5. SEX <i>M</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-30-00</i>	9. AGE (In years lost birthday) <i>69</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Steel Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Johnson Simpson</i>		14. MOTHER'S MAIDEN NAME <i>Emma Ripley</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-09-1626</i>		17. INFORMANT <i>Susie Simpson</i>	
18. <i>342X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Sustained Infection</i> (B) <i>Dementia Wern</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Parkinson's Disease, Fair Advanced</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 Days</i> <i>months</i> <i>Years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Duodenal Ulcer post Rastus Resection</i>				<i>Years</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>March 30</i> 19 <i>70</i> to <i>April 13</i> 19 <i>70</i> , that (T) (we) last saw the deceased alive on <i>April 13</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Peter H. Rheinsteim, MD</i>				23B. DATE SIGNED <i>April 14, 1970</i>	
23C. PHYSICIAN'S NAME (Type) <i>PETER H. RHEINSTEIN, MD</i>		23D. ADDRESS <i>1111 PARK AVENUE, BALTIMORE 1, MD.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>April 17/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>A.D. County Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 14 1970</i>			
25B. NAME OF REGISTRAR <i>Robert E. Fisher, MD.</i>		25C. FUNERAL DIRECTOR <i>Joseph E. Elukow</i>			
25D. ADDRESS <i>1129 N. Calhoun St.</i>					

6-463

70 3913

BALTIMORE CITY HEALTH DEPARTMENT

70 3913

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) ISAAC GAYLORD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1045 Greenmount Ave. (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 13 1970 7:15 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1001			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH Jan. 17/1926		10. AGE (In years last birthday) 44 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work, e.g., doer, dyling, masi of working life, ever II reitred) Unemployed		15. MOTHER'S MAIDEN NAME Nanah Moore	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Virginia Gaylord		ADDRESS 1845 Greenmount Ave.	
19. 345.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Epilepsy		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Epilepsy (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. DATE SIGNED 4-13-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/17/70	24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	24D. LOCATION (City, town, or county) (State) Arbutus Md.
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR York & Chilton	ADDRESS 11297 Caroline St

Thompson
Harrison
Thompson

ACADEMY

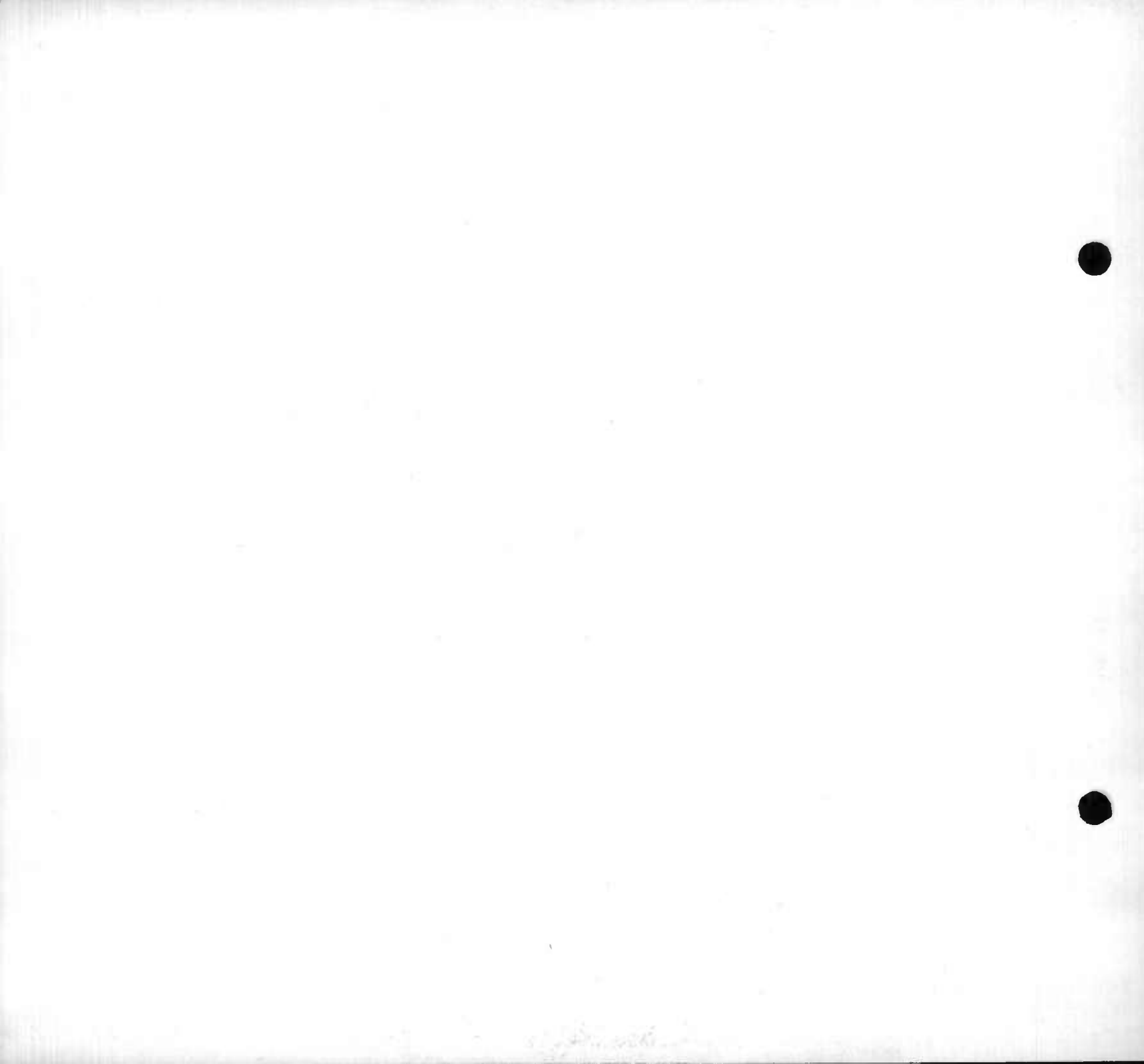
WILLIAM

Thompson
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FUNERAL DIRECTOR: IMPORTANT

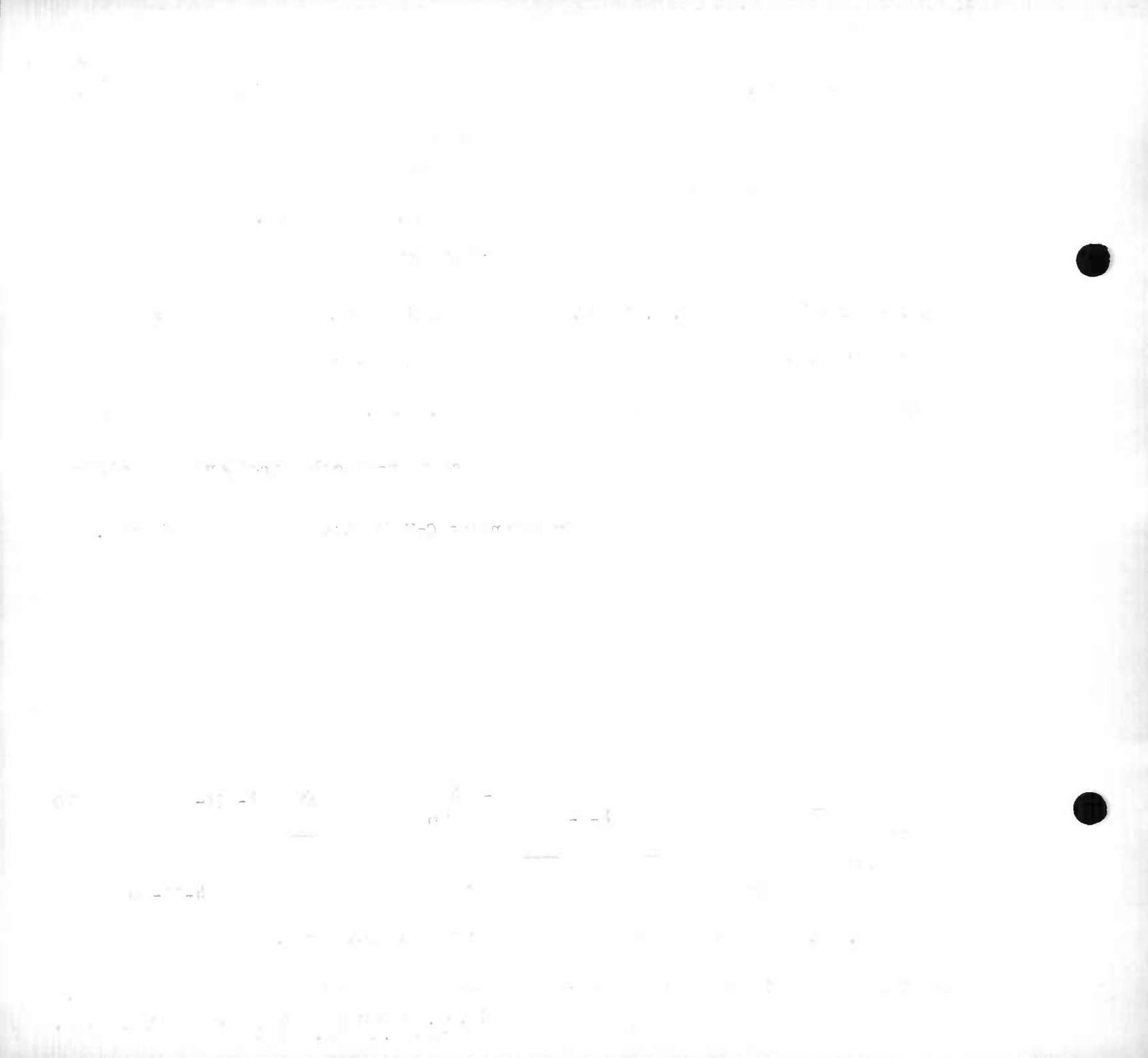
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3914	
70 3914				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Eugene GRAY</u>		2. DATE AND HOUR OF DEATH <u>4-9-70</u> <u>2 AM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1002</u>		5. CITY OR TOWN <u>CITY</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Harbor View Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6/9/04</u>		9. AGE (In years last birthday) <u>65</u>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Lucy Gray</u>		14. MOTHER'S MAIDEN NAME <u>GRACIE HARRIS</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-07-375</u>		17. INFORMANT <u>Lillie Mae Gray</u>	
18. <u>442X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>	
(B) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>Years</u>			
(C) <u>Alzheimer's Disease</u>		<u>2 Years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>27 March</u> 19 <u>70</u> to <u>9 April</u> 19 <u>70</u> that (2) (we) lost saw the deceased alive on <u>9 April</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Peter H. Rheinstein, MD</u>		23B. DATE SIGNED <u>9 April 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>PETER H. RHEINSTEIN, MD</u>		23D. ADDRESS <u>HARBOR VIEW, 1213 LIGHT ST</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/10/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Not. William Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Westport, MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 14 1970</u>		25B. NAME OF REGISTRAR <u>W. E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Milton Chikern</u>	
25D. ADDRESS <u>1629 N. Caroline St</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
4-620		70 3915		70 3915	
1. NAME OF DECEASED (Type or Print) John R. Parrish			2. DATE AND HOUR OF DEATH April 10, 1970 7 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence below admission) A. STATE Md. B. COUNTY 1206 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2833 N. Howard St.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-1897	9. AGE (In years lost birthday) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Machinist		10B. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Parrish			14. MOTHER'S MAIDEN NAME Adelia Wolford		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-40-4046	17. INFORMANT Mrs. J.R. Parrish		ADDRESS Same
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) cerebro-vascular accident Hypertensive C-V disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 17 yrs.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-4-1953 to 4-10-1970 that (I) (we) last saw the deceased alive on 4-8-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Ellsworth Cook			23B. DATE SIGNED 4-13-70		
23C. PHYSICIAN'S NAME (Type) Dr. E. Ellsworth Cook			23D. ADDRESS 2431 Maryland Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		24E. NAME OF REGISTRAR H.W. Jenkins Sons Co. 4905 York Rd. Balto., Md. 21212			
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR H.W. Jenkins Sons Co.		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Balto., Md. 21212	



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Edward DALE GERLACH		Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 4 11 70 2:55 p M.		Month Day Year April 11, 1970 2:55 p M.		Balto. City Hospital		A. STATE Maryland B. COUNTY 2652	
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH January 19, 1960 10		10. AGE (In years lost birthday) 10	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Donald E Gerlach		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		15. MOTHER'S MAIDEN NAME Katherine CX Monroe	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None		18. INFORMANT Mr Donald E Gerlach		19. CAUSE OF DEATH		ADDRESS Same	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE Multiple injuries		DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no					
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, locality, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Southbound lane of Harbor tunnel through way N. of Moravia Rd.		22D. TIME (Month) (Day) (Year) (Hour) 4 11 70 2:31		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/70		24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland					

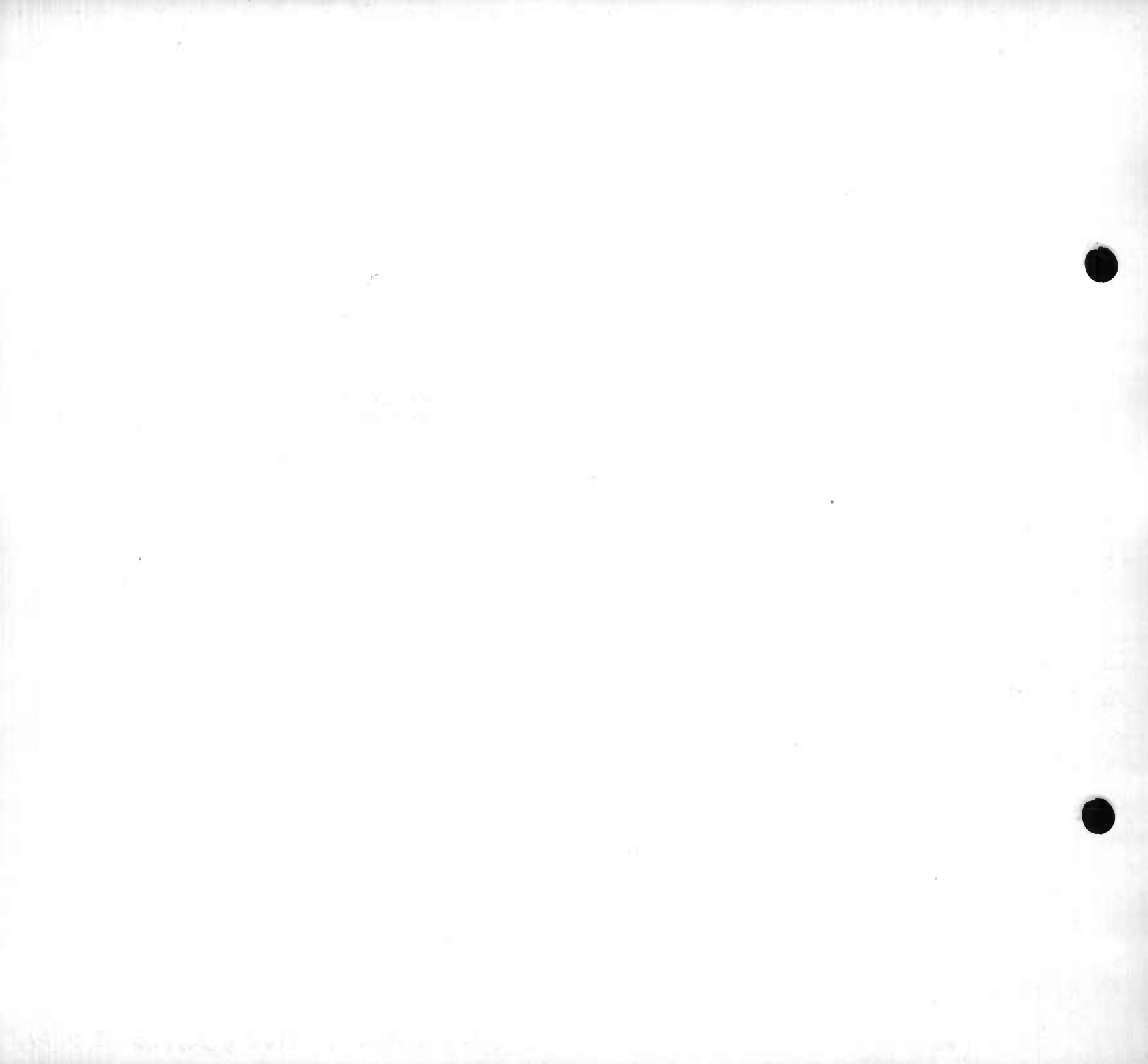
1/15/70

Richard J. Hunt, Jr., Raleigh, N.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

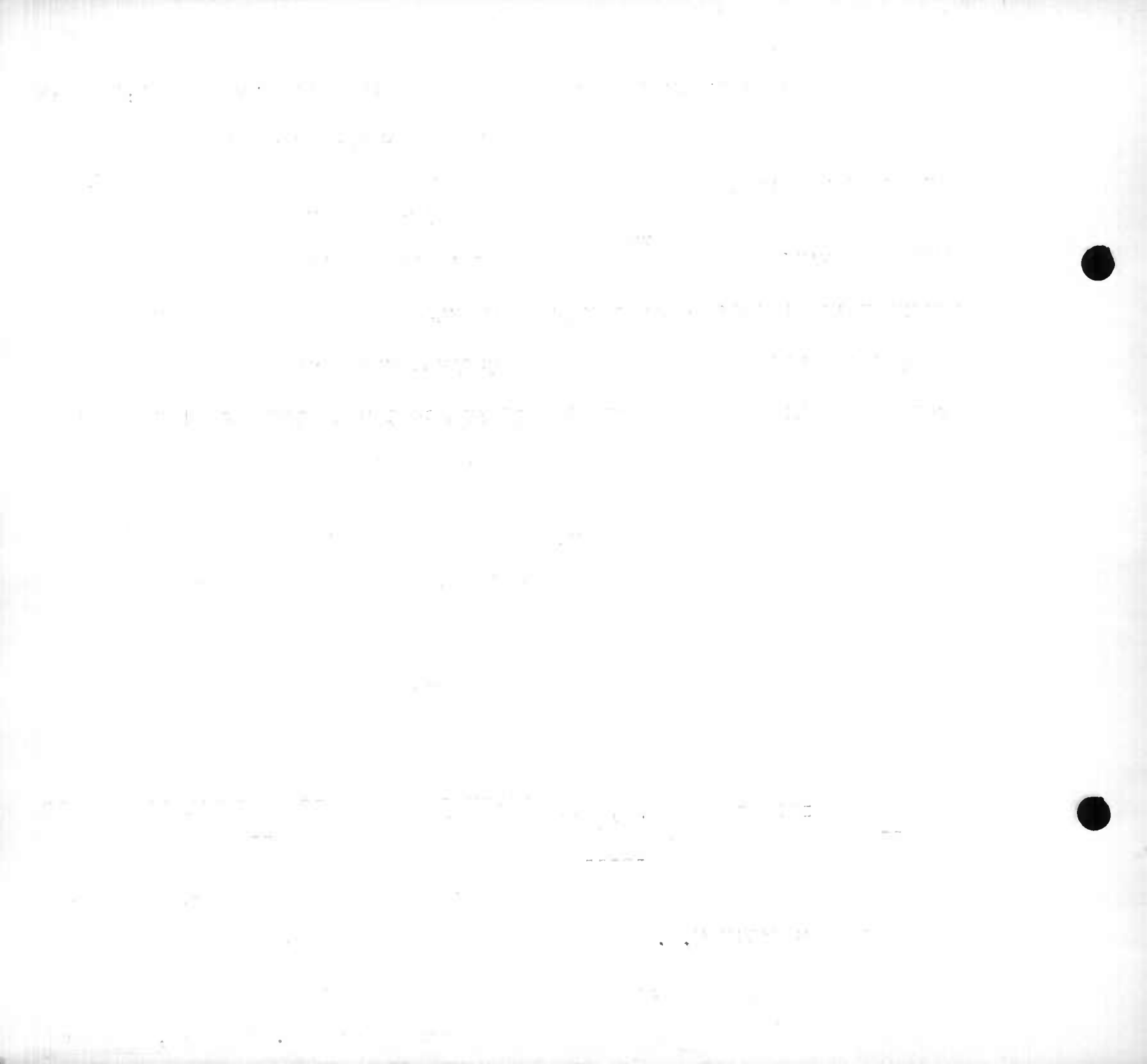
P-200 70 3917		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3917	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM EDWARD PASCO		2. DATE AND HOUR OF DEATH APRIL 10, 1970 12:25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2706		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES GEN. HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-5-17		9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS PASCO	
14. MOTHER'S MAIDEN NAME CHRISTINA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-3120	
17. INFORMANT MRS. EVELYN L. PASCO		ADDRESS (SAME)		18. CAUSE OF DEATH Severe bilat. pneumonia	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarct		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that he (this hospital) attended the deceased from 4/8 19 70 to 4/10 19 70 that (I) we last saw the deceased alive on 4/10 19 70 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death.					
23A. SIGNATURE Nilda Cabiling MD		23B. DATE SIGNED 4/10/70		23C. PHYSICIAN'S NAME (Type) NILDA CABILING MD	
23D. ADDRESS NORTH CHARLES GENERAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/13/70	
24C. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.		25A. DATE REC'D BY HEALTH DEPT. APR 14 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, MD.		25C. FUNERAL DIRECTOR LEONARD J. Ruck, Inc.		ADDRESS BALTA 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
F-462 70 3918					CERTIFICATE OF DEATH				
BIRTH NO.					REG. NO. 70 3918				
1. NAME OF DECEASED (Type or Print) LEONARD LEROY FLOWERS					2. DATE AND HOUR OF DEATH APRIL 11 1970 4:47 PM.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL					A. STATE MD				
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION					B. COUNTY HOWARD COUNTY				
					C. CITY OR TOWN LAUREL		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER 928 LYON AVENUE				
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05 19 22	9. AGE (In years last birthday) 47	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PSYCHIATRIC AIDE #5				10B. KIND OF BUSINESS OR INDUSTRY SPRING GROVE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ERNEST FLOWERS					14. MOTHER'S MAIDEN NAME ELEANOR KLAPASKI				
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR 2				16. SOCIAL SECURITY NO. 217 14 9236		17. INFORMANT ADDRESS ST AGNES HOSP CATON & WILKENS AVE			
18. CAUSE OF DEATH 410.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					(A) IMMEDIATE CAUSE Bacterial pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) acute myocardial infarct with DUE TO, OR AS A CONSEQUENCE OF: (C) cardiorespiratory arrest.				
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from MARCH 5 19 70 to APRIL 11 19 70 that (I) (we) last saw the deceased alive on APRIL 11 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Rafael H Marin</i>					23B. DATE SIGNED 4/11/70			23C. PHYSICIAN'S NAME (Type) RAFAEL H MARIN M.D.	
23D. ADDRESS St Agnes Med. Center 21229									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/70		24C. NAME OF CEMETERY or CREMATORY Fork Methodist		24D. LOCATION (City, town, or county) (State) Baltimore County Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR J. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc.		25D. ADDRESS Baltimore, Maryland			



FUNERAL DIRECTOR: IMPORTANT

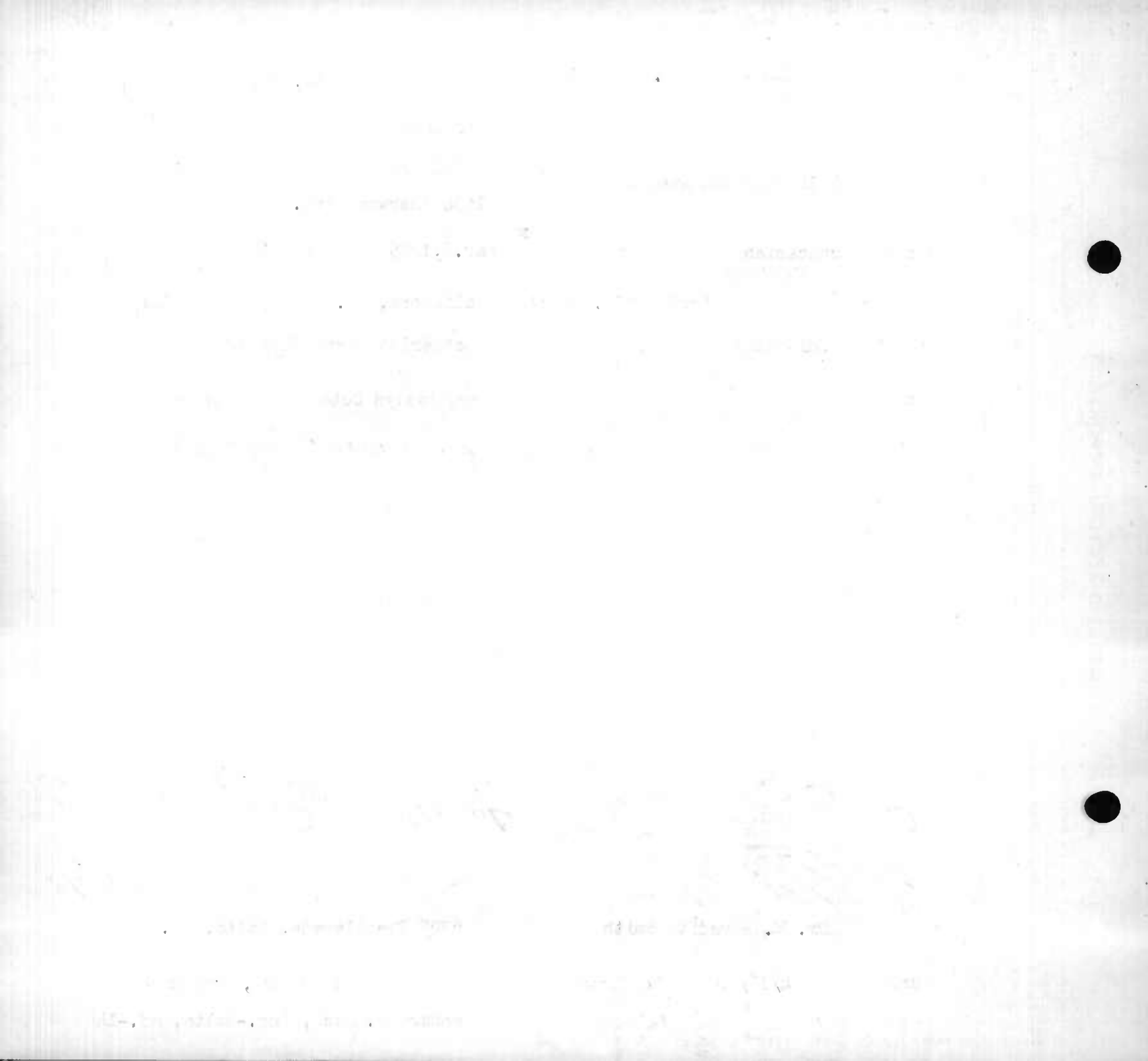
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-535		70 3919		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3919	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) LINTON, Clarence Alton			
2. DATE AND HOUR OF DEATH 10 APRIL 1970 2:45 P				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21206				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE				6. RACE CAUCASION		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-22-08				9. AGE (In years last birthday) 61		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET WORKER				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SHADY SIDE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME CLARENCE LINTON			
14. MOTHER'S MAIDEN NAME MARY GRAMBODT				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 2-27-43 TO 6-29-43			
16. SOCIAL SECURITY NO. 212-07-24-34				17. INFORMANT VA HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTO, MD 21218			
18. CAUSE OF DEATH 5-19-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asithenia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: 2° COR PULMONALE CHRONIC OBSTRUCTIVE AIRWAY DISEASE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that 03 (this hospital) attended the deceased from 19 MARCH 19 70 to 10 APRIL 19 70 that 02 (we) last saw the deceased alive on 10 APRIL 19 70 and that 02 (our) opinion death occurred on the date and hour and from the causes stated above. 02 (We) (did) 02 view the body after death.							
23A. SIGNATURE Raymond E. Knowles, Jr. M.D.				23B. DATE SIGNED 13 APRIL 1970		23C. PHYSICIAN'S NAME (Type) RAYMOND E. KNOWLES, JR., M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/70.		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Sabin, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

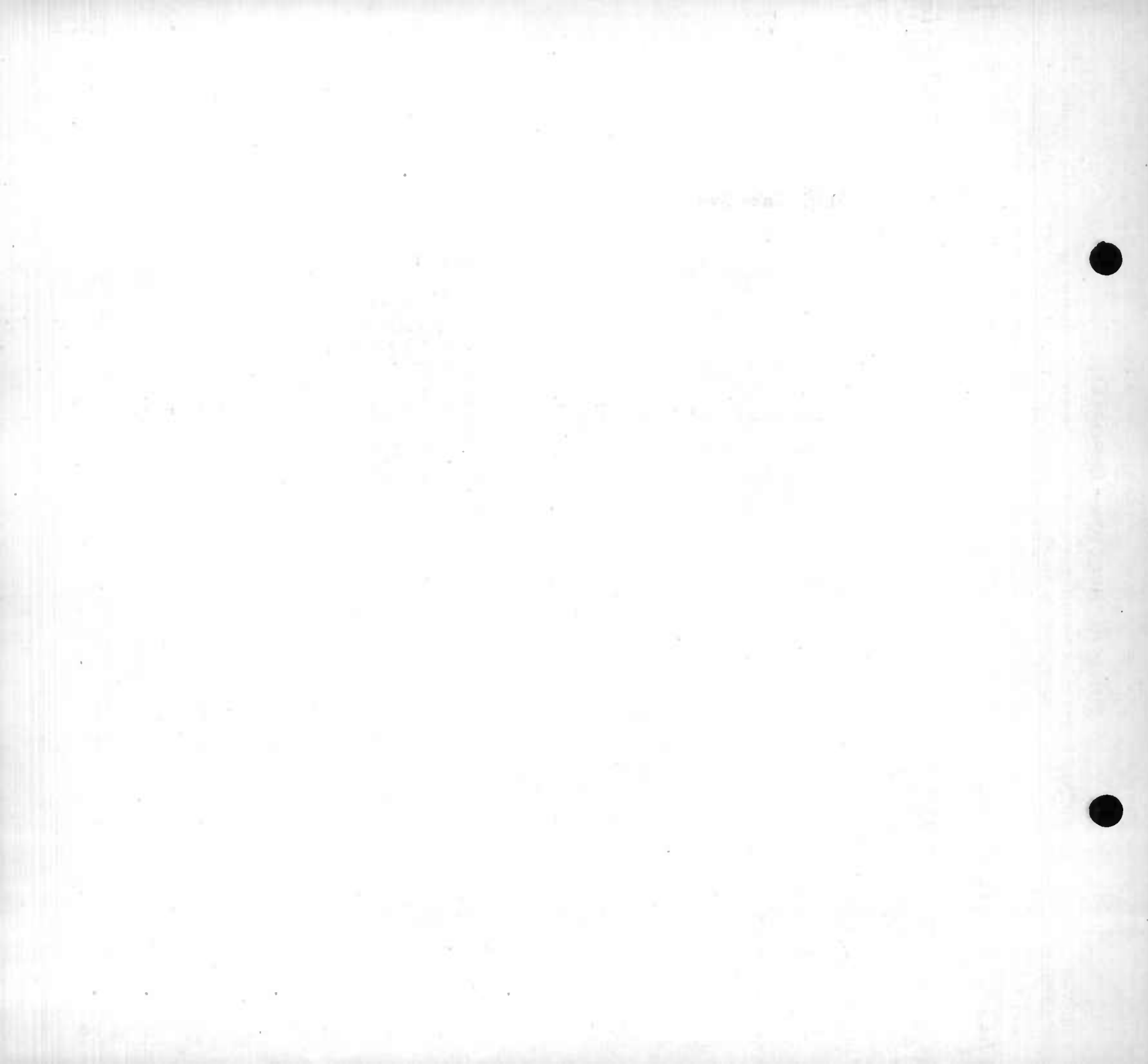
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3920	
BIRTH NO. H-500 70 3920		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HELEN A. HEIM		2. DATE AND HOUR OF DEATH April 12, 1970 12:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1634 Sherwood Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 2758	
		C. CITY OR TOWN Baltimore	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1634 Sherwood Ave.	
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 7, 1905
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY Lord Balto. Hotel	9. AGE (In years last birthday) 65
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emil Heim		14. MOTHER'S MAIDEN NAME Catherine Sarah Shirley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Evelyn Cobb
			ADDRESS Same
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		CAUSE OF DEATH Massive Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20A. AUTOPSY? (Yes or No) —	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natally medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1968 to March 1970 , that (I) (we) last saw the deceased alive on March 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE W. M. Smith		23B. DATE SIGNED 4/13/70	
23C. PHYSICIAN'S NAME (Type) Dr. W. Meredith Smith		23D. ADDRESS 6305 The Alameda, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/15/70	24C. NAME of CEMETERY or CREMATORY Woodlawn	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970	25B. NAME OF REGISTRAR R. E. Fisher, M.D.	25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc.-Balto, Md.-14	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3921	
<div style="display: flex; justify-content: space-between;"> F-420 70 3921 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Anna P Flick		4-10-70 7 ⁴⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 317 ¹ / ₂ E Lake Ave			A. STATE Maryland		
			B. COUNTY Balto.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX F			6. RACE W		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			8. DATE OF BIRTH		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9-4-91		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)
Retired Governess					78
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Germany			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Adolph F Flick			Regina W Debus		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			217-34-8430		Mrs Gertrude F Von Hofe, 317 E Lake Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			Pneumonia		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Ca lung		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from July 1960 to April 10 1970, that (I) last saw the deceased alive on 4/10 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William F Fritz				4/18/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
William F. Fritz, M. D.				21218 2 W. University Parkway Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4-14-70		Moreland Cem.	
24D. LOCATION		24E. LOCATION		24F. LOCATION	
Balto.		Balto.		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 14 1970		Leonard J Ruck Inc		5305 Harford Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

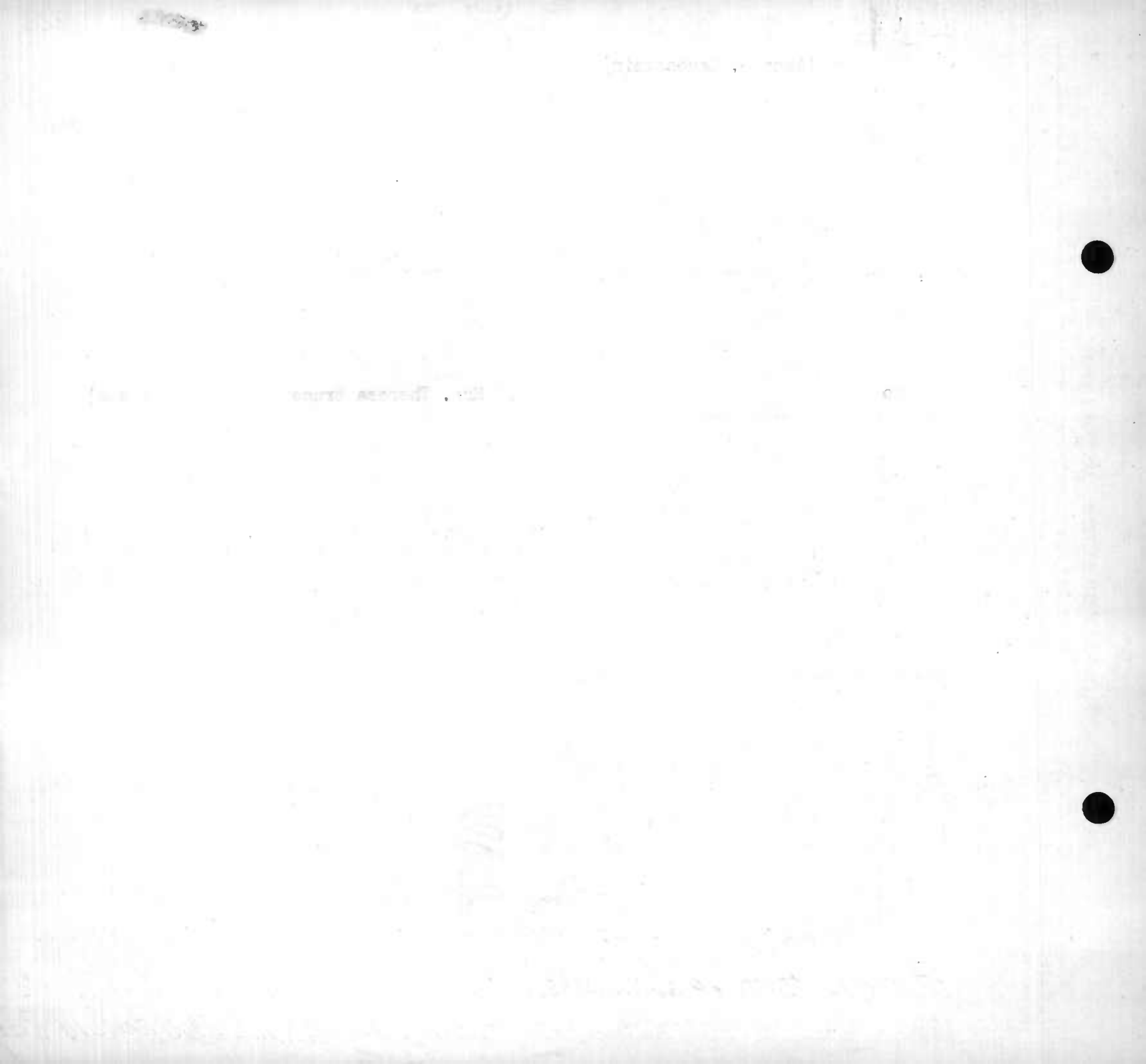
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3922	
<div style="font-size: 1.5em; font-weight: bold;">M-226 70 3922</div> <div style="font-size: 1.2em; font-weight: bold;">70-06394</div>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY GIRL McCUSKER			2. DATE AND HOUR OF DEATH 4-12-70 12:35 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-06 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5614 Pilgrim Road		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-70	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 32
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME JOHN CHARLES McCUSKER		
14. MOTHER'S MAIDEN NAME JOYCE BERTHA TWEEDLE			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS John C McCusker 5614 Pilgrim Rd.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Prematurity		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4-12-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 12 19 70 to April 12 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodolfo P. Velasco M.D.				23B. DATE SIGNED 4-12-70	
23C. PHYSICIAN'S NAME (Type) RODOLFO P. VELASCO, M.D.				23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-14-70		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 14 1970			
25B. NAME OF REGISTRAR R. E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc 5305 Harford Rd			

WASH. D.C. - MAY 1964

or visit

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 40		3923	
L-523		70 3923		CERTIFICATE OF DEATH			
BIRTH NO.				1. NAME OF DECEASED (Anna M. Lauenstein)			
(Type or Print) <i>Anna M. Lauenstein</i>				2. DATE AND HOUR OF DEATH <i>4-12-70 10pm M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE <i>Maryland</i>		B. COUNTY <i>101</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View H.C.C.</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<i>101213 Light St. Balt 30</i>				E. STREET AND NUMBER <i>1318 Lenwood Ave.</i>			
5. SEX <i>F</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-13-01</i>	9. AGE (In years last birthday) <i>68 yrs</i>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Mal O. Etzel</i>				14. MOTHER'S MAIDEN NAME <i>May Schuman</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>217-01-7136</i>		17. INFORMANT <i>Mrs. Theresa Bruce</i>	
18. <i>410.01 + 250.9</i>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <i>acute coronary occlusion</i>		<i>minutes</i>	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) <i>Hypertensive C.V. disease</i>		<i>years</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <i>arteriosclerosis gen</i>		<i>years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<i>Diabetes mellitus</i>		<i>years</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5/22 1969</i> to <i>7/12 1970</i> , that (I) (we) last saw the deceased alive on <i>7/12 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>ALLAN H. MACHT MD</i>				23B. DATE SIGNED <i>4/11/70</i>			
23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT MD</i>				23D. ADDRESS <i>2 E Pearl St Balt Md 21202</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>4/14/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Michael's Lutheran Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Coun Ty - Balt Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 14 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Rucklins</i>		ADDRESS <i>5305 Harford Rd</i>	



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
DANIEL GETTIER		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		Full Name of Hospital or Institution (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
Union Memorial Hospital		Balto.		4 12 1970 7:10 A.M.		Md. 904			
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		April 21, 1935.		34	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
Maryland		USA		Walter L. Gettier		Warehouseman		Catherine Young	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		20. DATE OF OPERATION	
No		217-30-4775		Mr. Russel W. Gettier, 5106 Edgar Terrace #14		Multiple 3rd degree burns		8	
21. CAUSE OF DEATH		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		24. TIME OF INJURY (APPROX.)		25. INJURY OCCURRED	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		basement		1433 Carswell St. 905		3-11-70 11 P.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C) DUE TO, OR AS A CONSEQUENCE OF:									
26. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No)		30. CHIEF MEDICAL EXAMINER	
						no		[Signature] M.D.	
31. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		34. TIME OF INJURY (APPROX.)		35. INJURY OCCURRED	
		basement		1433 Carswell St. 905		3-11-70 11 P.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
36. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		37. CHIEF MEDICAL EXAMINER		38. ASSISTANT MEDICAL EXAMINER		39. ASSOCIATE MEDICAL EXAMINER		40. DATE SIGNED	
Russell S. Fisher, M.D.		[Signature]						4-13-70	
41. BURIAL CREMATION, REMOVAL (Specify)		42. DATE		43. NAME OF CEMETERY or CREMATORY		44. LOCATION (City, town, or county) (State)		45. FUNERAL DIRECTOR ADDRESS	
Burial		4/15/70.		Oaklawn Cemetery		Baltimore, Md.		Leonard J. Ruck, Inc. Balto. Md. 21214	
46. DATE REC'D BY HEALTH DEPT.		47. NAME OF REGISTRAR		48. FUNERAL DIRECTOR		49. ADDRESS		50. DATE SIGNED	
APR 14 1970		Russell S. Fisher, M.D.		Leonard J. Ruck, Inc.		Balto. Md. 21214		4-13-70	

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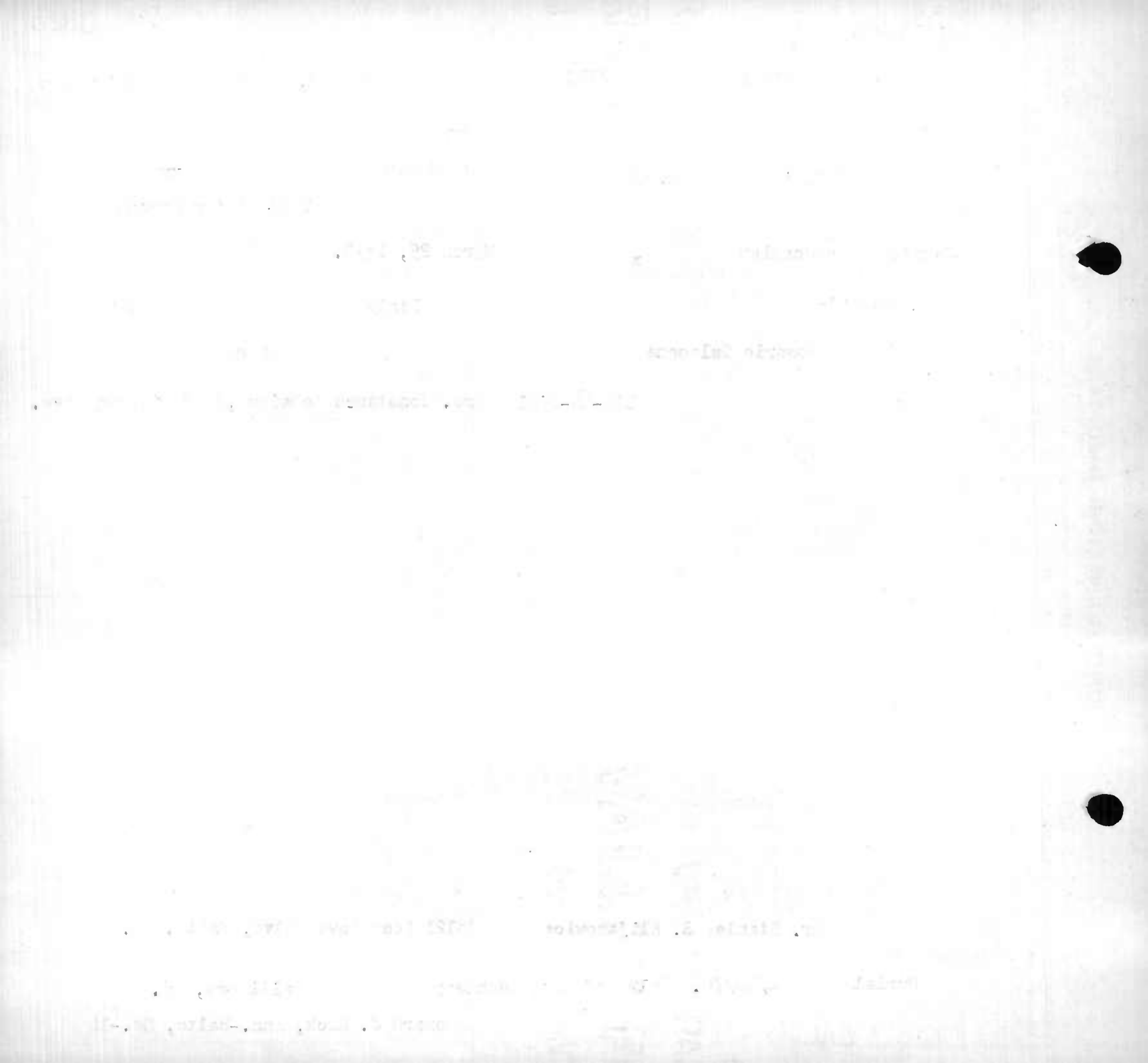
Laird

Journal of the American Medical Association

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
F-420		70 3925		70 3925	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
NANCY FUICA			April 13, 1970 5:25 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 GOULD'S CONVALESARIUM			A. STATE Maryland		
			B. COUNTY 2733		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2503 Albion Avenue		
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1893.	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Rosario Salamone		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-48-8501		17. INFORMANT ADDRESS Mrs. Constance LeMaitre, 8802 Richmond Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		CAUSE OF DEATH Left ventricular failure & pulmonary edema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary C. VD - Hemiplegia left (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. - 2 yrs. - 1 mo. - 5 yrs. -	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 3-17 1970 to 4-13 1970, that (I) (we) last saw the deceased alive on 4-13 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley B. Klijanowicz M.D.			23B. DATE SIGNED 4-13-70		23C. PHYSICIAN'S NAME (Type) Dr. Stanley B. Klijanowicz
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/16/70.		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) Baltimore, Md.			25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		
25B. NAME OF REGISTRAR R. E. Jaber, M.D.			25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. - Balto, Md. - 14		



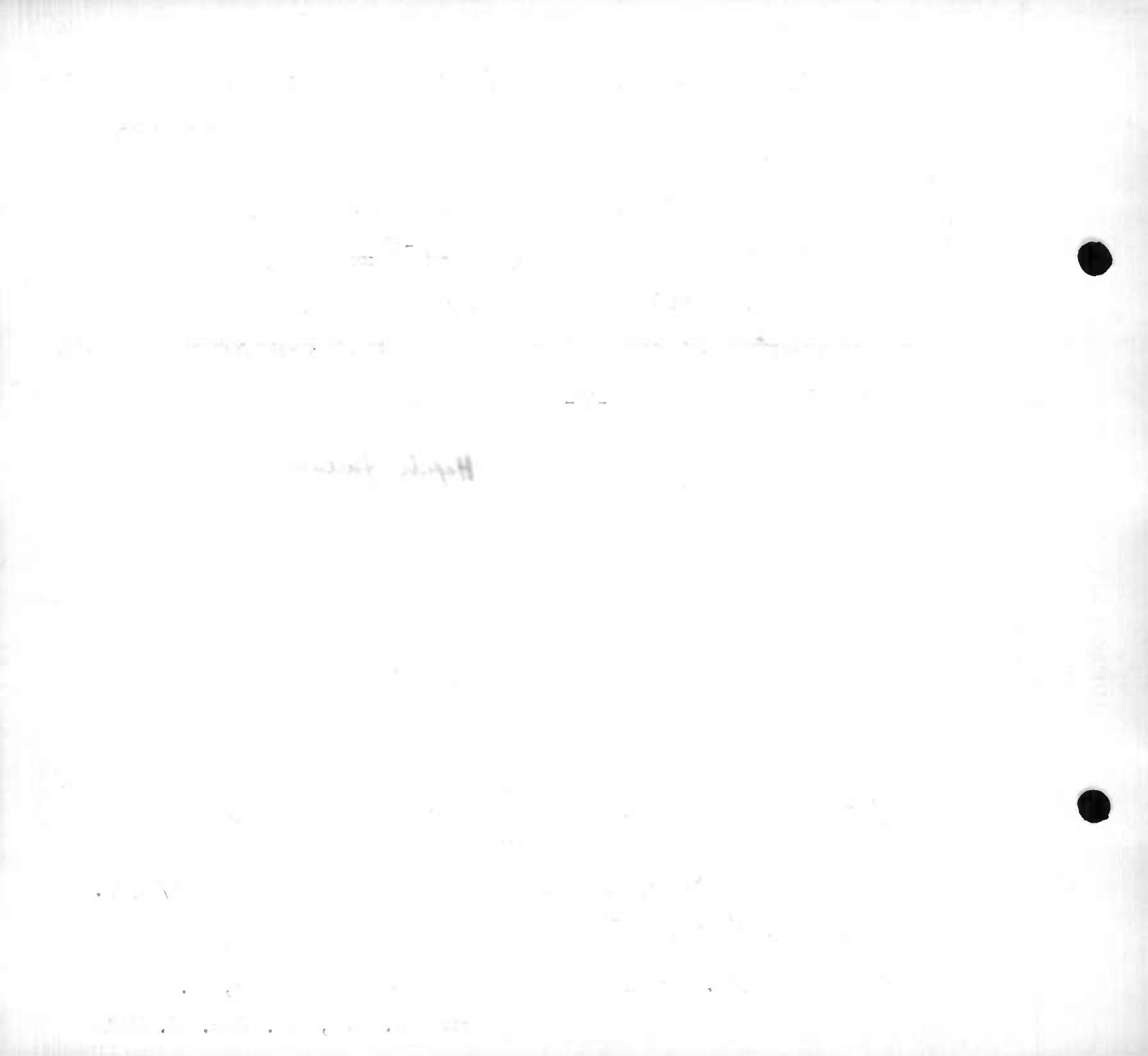
H-500		70 3926		BALTIMORE CITY HEALTH DEPARTMENT		X		70 3926	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.			
1. NAME OF DECEASED (Type or Print) J. ANTHONY HUHN									
2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M.									
3. DATE PRONOUNCED DEAD Month Day Year Hour M.									
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL, ADDRESS OR LOCATION 46 Lutheran Hospital									
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
6. SEX Male 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
9. DATE OF BIRTH June 26, 1906 10. AGE (In years last birthday) 63 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA 13. FATHER'S NAME John Huhn									
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Mgr. 14B. KIND OF BUSINESS OR INDUSTRY Ice Cream Co. 15. MOTHER'S MAIDEN NAME Agnes Stegonski									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 17. SOCIAL SECURITY NO. 212-09-2329 18. INFORMANT Mrs. Mildred R. Huhn ADDRESS (Same)									
19. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 2004 21. AUTOPSY? (Yes or No) yes									
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) service station 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2501 W. Franklin St.									
22D. TIME OF INJURY (APPROX.) 4-12-70 3:25 P. m. 22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR? Subj. shot during holdup by unknown assailants.									
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-13-70									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/16/70. 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Md.									
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. ADDRESS Balto. Md. 21214									

V.S. 153 and Letter from M.E.'s office
4-20-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

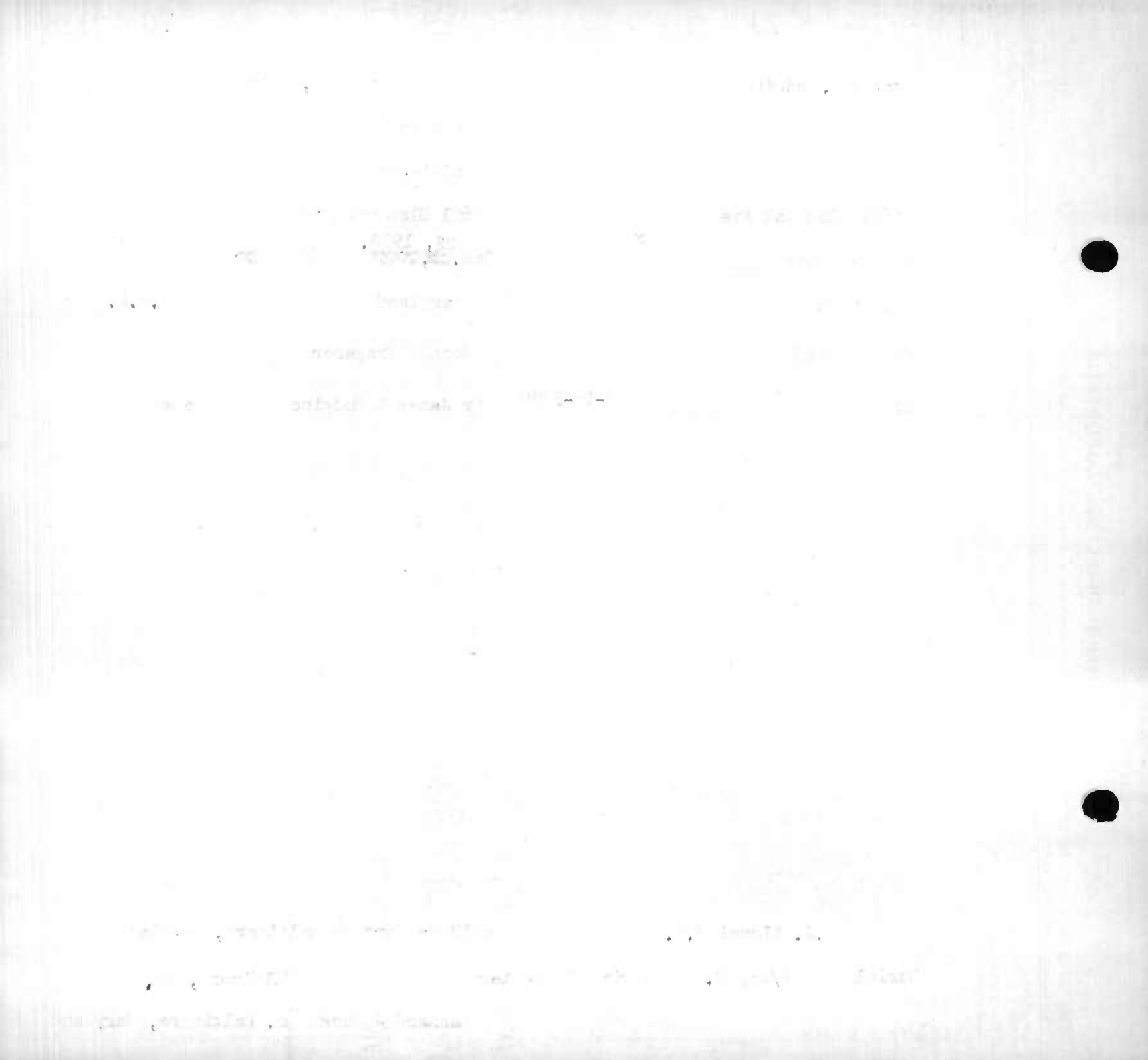
D-650 70 3927		BALTIMORE CITY HEALTH DEPARTMENT		70 3927	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) DURHAM, ADDIE RUTH		2. DATE AND HOUR OF DEATH April 13, 1970, 9, 15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 316 E. LORRAINE AVENUE			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-31-33	9. AGE (In years last birthday) 36	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY (None)		11. BIRTHPLACE (State or foreign country) TENNESSEE	
13. FATHER'S NAME Worley Durham		14. MOTHER'S MAIDEN NAME Pearl Riley			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-32-0528		17. INFORMANT NAN M. DURHAM ADDRESS LANSDOWNE Md.	
18. 57391 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Hepatic failure DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Involuntarily medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 04-20-70 to 04-13-70 that (I) (we) last saw the deceased alive on 04-13-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.P. Mikus		23B. DATE SIGNED 4/13/70.		23C. PHYSICIAN'S NAME (Type) J.P. MIKUS M.D.	
23D. ADDRESS Union Memorial Hospital		23E. NAME OF REGISTRAR Robert E. Taylor, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/16/70.		24C. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	
24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 14 1970			
25B. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		25C. ADDRESS alto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

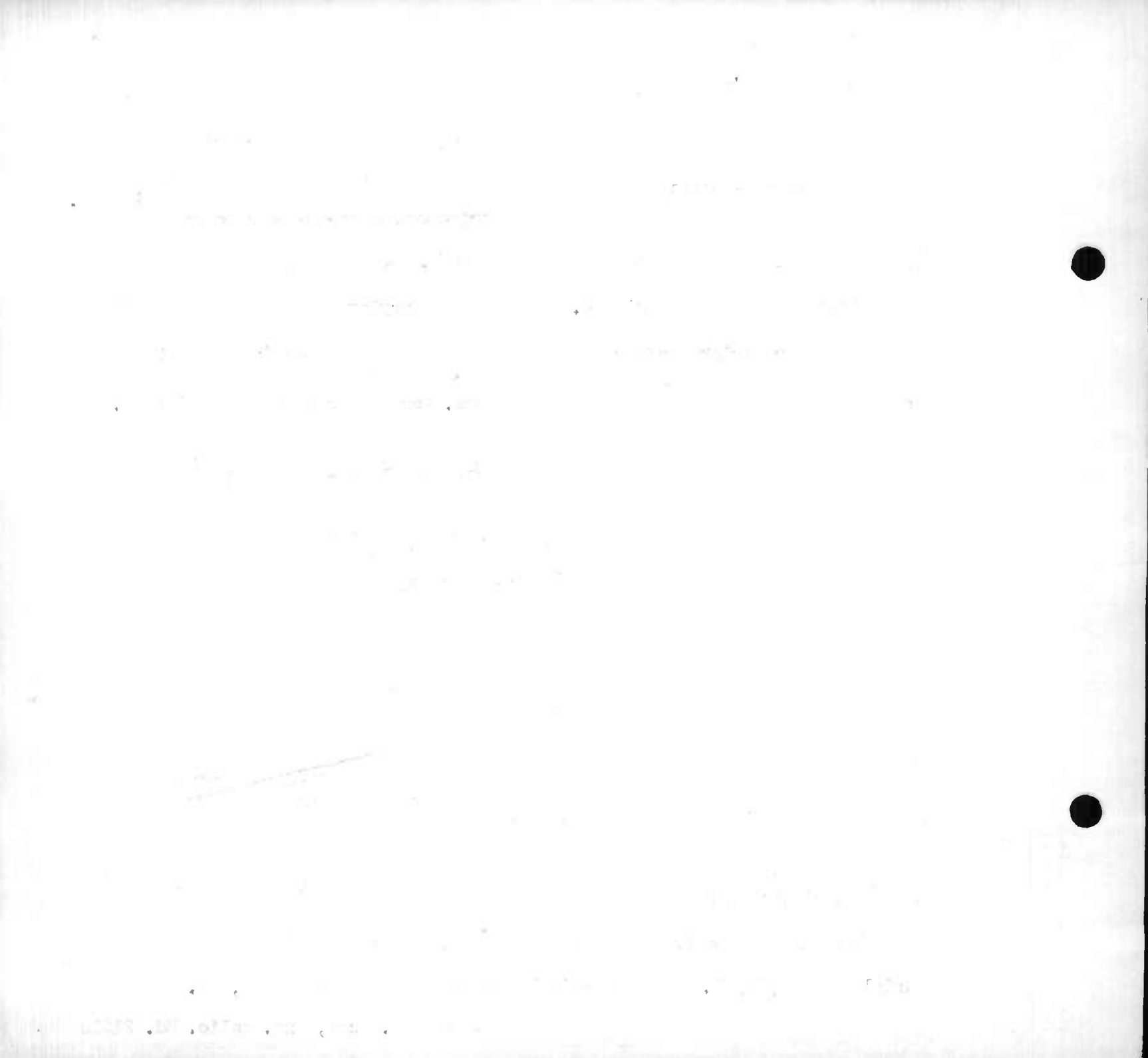
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3928	
<div style="display: flex; justify-content: space-between;"> 14-325 70 3928 CERTIFICATE OF DEATH </div>					
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Marie G. Hudgins			2. DATE AND HOUR OF DEATH April 12, 1970 12:30 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 2em; margin-left: 10px;">00</div> 6601 Glen Oak Ave			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2735 5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6601 Glen Oak Ave		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22, 1920. Dec. 22, 1920	9. AGE (In years last birthday) 49 48	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME John A Reed		
14. MOTHER'S MAIDEN NAME Sophia Trageser			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-16-9820			17. INFORMANT Mr James L Hudgins ADDRESS Same		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 3 months			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 9 1950 to April 12 1970, that (I) (we) last saw the deceased alive on April 12 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 4/13/70	
23C. PHYSICIAN'S NAME (Type) E.J. Alessi M.D.,				23D. ADDRESS 6217 Harford Rd Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/70.		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 14 1970			
25B. NAME OF REGISTRAR E. J. Alessi, M.D.		25C. FUNERAL DIRECTOR Leonard J Ruck I c. Baltimore, Maryland			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-160		70 3929		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3929	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) NORMAN F. Shaffer			
2. DATE AND HOUR OF DEATH 4/13/70 12:11 A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md		B. COUNTY Baltimore	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5334 Cordella Ave.			
5. SEX M		6. RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/6/07	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Transit Co.		9. AGE (in years last birthday) 63		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick Shaffer		14. MOTHER'S MAIDEN NAME Julia ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Noreen Christian, Woodbine Md.		ADDRESS	
18. 492X14-185X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute Pulmonary Insufficiency DUE TO, OR AS A CONSEQUENCE OF: (B) Chronic Emphysema DUE TO, OR AS A CONSEQUENCE OF: (C) Cancer of prostate				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? Indify medical examiner		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month () Day () Year () Hour ()		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/10 19 70 to 4/10 19 70 and that (I) (we) last saw the deceased alive on 4/10 19 70 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Victor S. Schneider, M.D.				23B. DATE SIGNED 4/13/70			
23C. PHYSICIAN'S NAME (Type) Victor S. Schneider M.D.				23D. ADDRESS Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/16/70.		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	

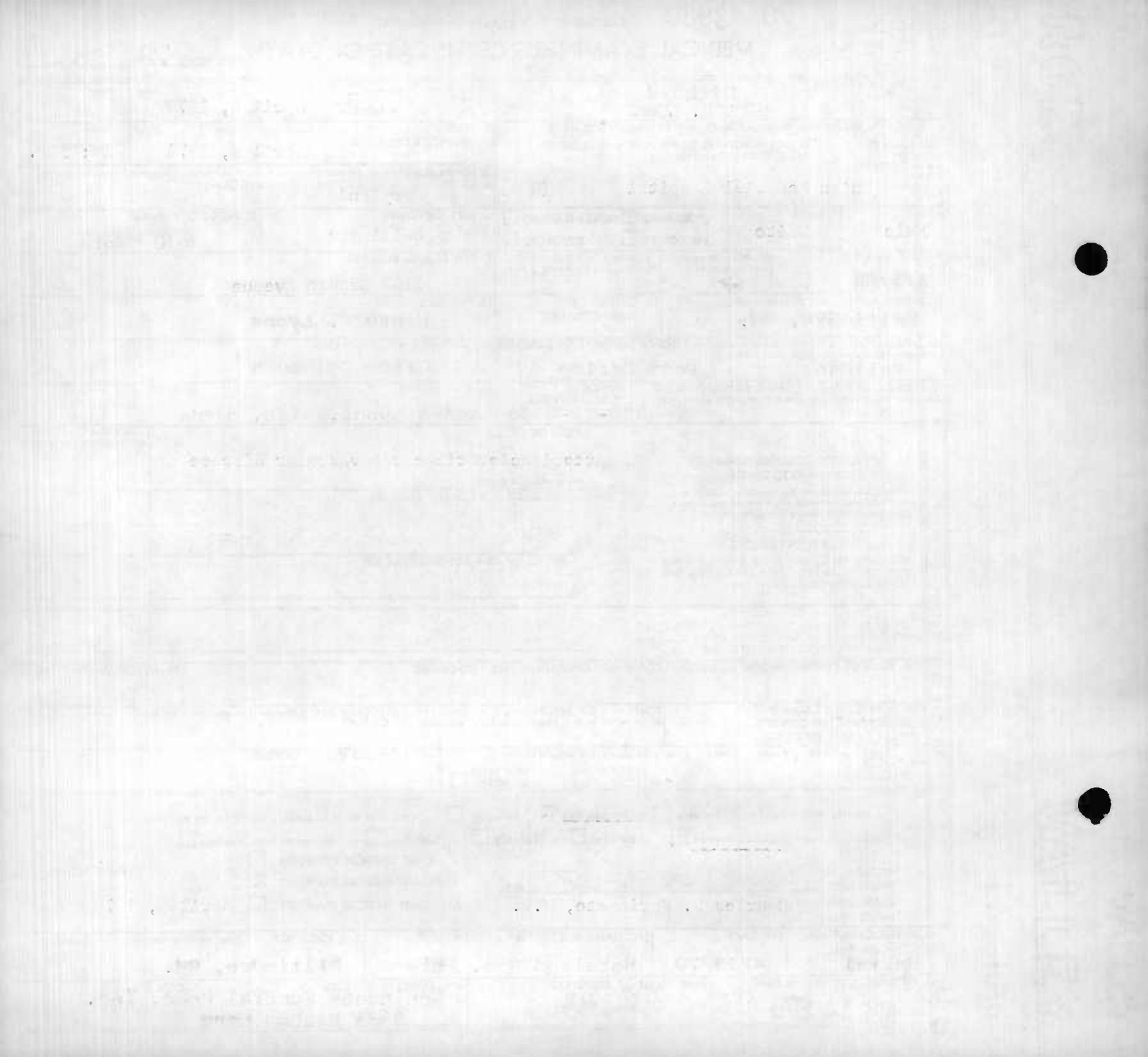


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3930

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Richard HARRY R. LYONS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 8, 1970		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year April 8, 1970		Hour 10:15 P.M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 841		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 3103 Erdman Avenue
9. DATE OF BIRTH 4/3/03		10. AGE (in years last birthday) 67		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Henry F. Lyons		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mailman
15. MOTHER'S MAIDEN NAME Grace Colbourn		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 220-22-4756
18. INFORMANT Agnes Lyons, wife, above		19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 9, 1970 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/70		24C. NAME of CEMETERY or CREMATORY Moreland Mem. Park
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

G-456 70 3931		BALTIMORE CITY HEALTH DEPARTMENT		70 3931	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) MRS. MARIE M. GILNER			2. DATE AND HOUR OF DEATH APRIL 11, 1970 12:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY 2664		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3532 E. FAYETTE ST.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-11	9. AGE (in years last birthday) 58	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN		10B. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (State or foreign country) Baltimore MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICA
13. FATHER'S NAME JOHN SCHULTZ			14. MOTHER'S MAIDEN NAME JULIA Milanicz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-30-6297	17. INFORMANT STEX		ADDRESS 21221
			Yvonne M. Maunes, dght.		104 N. Stuart
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.91 Subarachnoid Hemorrhage			CAUSE OF DEATH Subarachnoid Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease		years
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Toxic Hepatitis		2 weeks
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from April 5 19 70 to April 11 19 70 that (we) last saw the deceased alive on April 11 19 70 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Cezar A. Lopez MD			23B. DATE SIGNED April 11, 1970		
23C. PHYSICIAN'S NAME (Typed) CEZAR A. LOPEZ MD			23D. ADDRESS CHURCH HOME AND HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/70		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home Inc.	
				ADDRESS 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

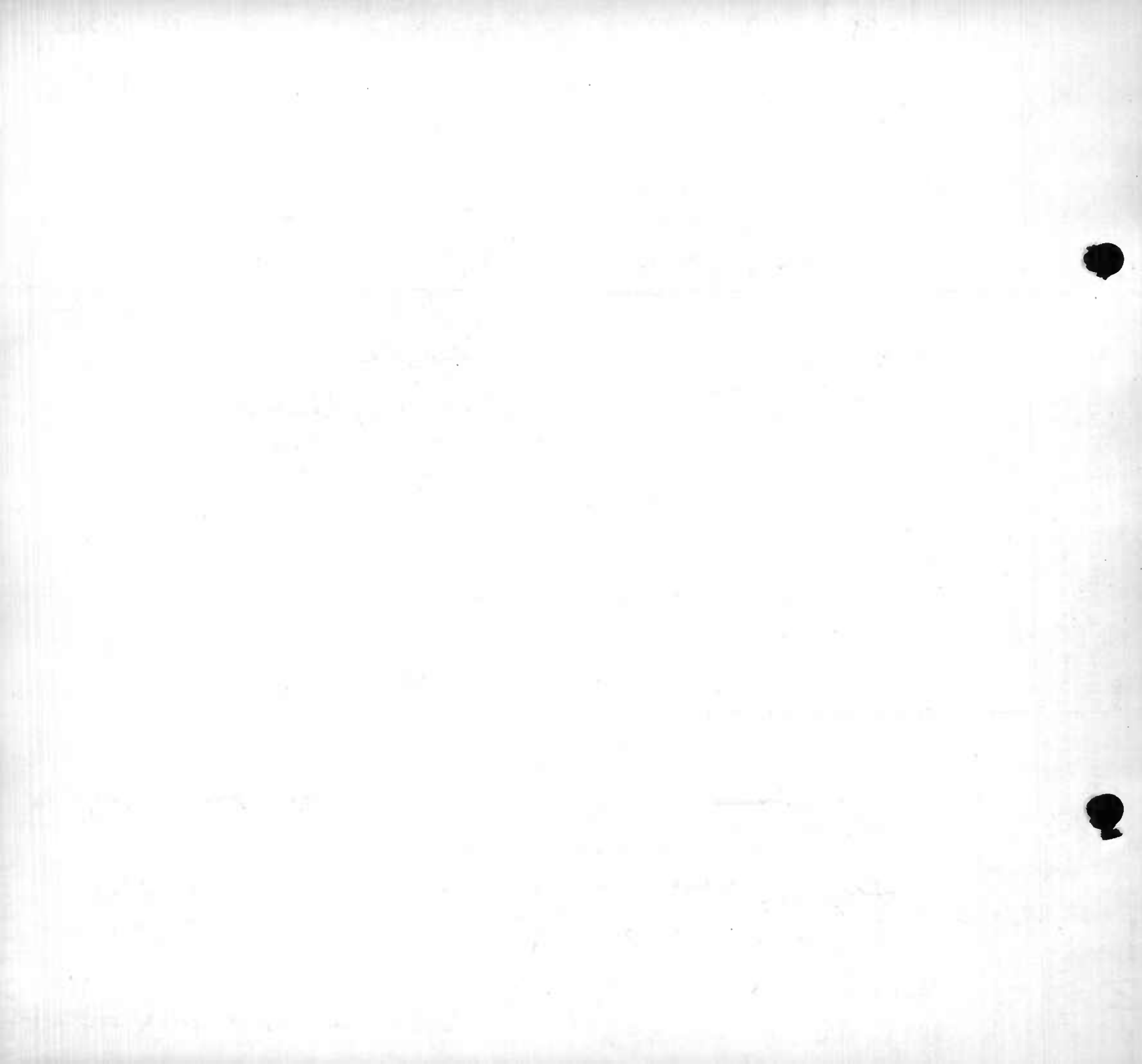
K-320 70 3932		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3932	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ALICE KATZ		2. DATE AND HOUR OF DEATH APRIL 11/70 10⁴⁵ P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2719		C. CITY OR TOWN BALTO	
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in the Pines, Beloe		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 5407 Dist Ave	
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1914	9. AGE (In years last birthday) 55	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Security		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis, Mo	
13. FATHER'S NAME Adolph		14. MOTHER'S MAIDEN NAME Thurson		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 093-14-8772		17. INFORMANT May Katz	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 174X I		CAUSE OF DEATH Carcinoma of breast metastatic (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: None (B) DUE TO, OR AS A CONSEQUENCE OF: None (C) None		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 20 1968 to April 11 1970 that (I) (we) last saw the deceased alive on April 11 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuel Levin		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/11/70	
23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN		23D. ADDRESS 6101 PARK HTS AVE BALTO MD 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/70		24C. NAME of CEMETERY or CREMATORY Chesa Chesa Chapel	
24D. LOCATION (City, town, or county) (State) Randallstown Md		25A. DATE REC'D BY HEALTH DEPT. APR 14 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Sylvan Levin & Son 9610 Reservoir Rd			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

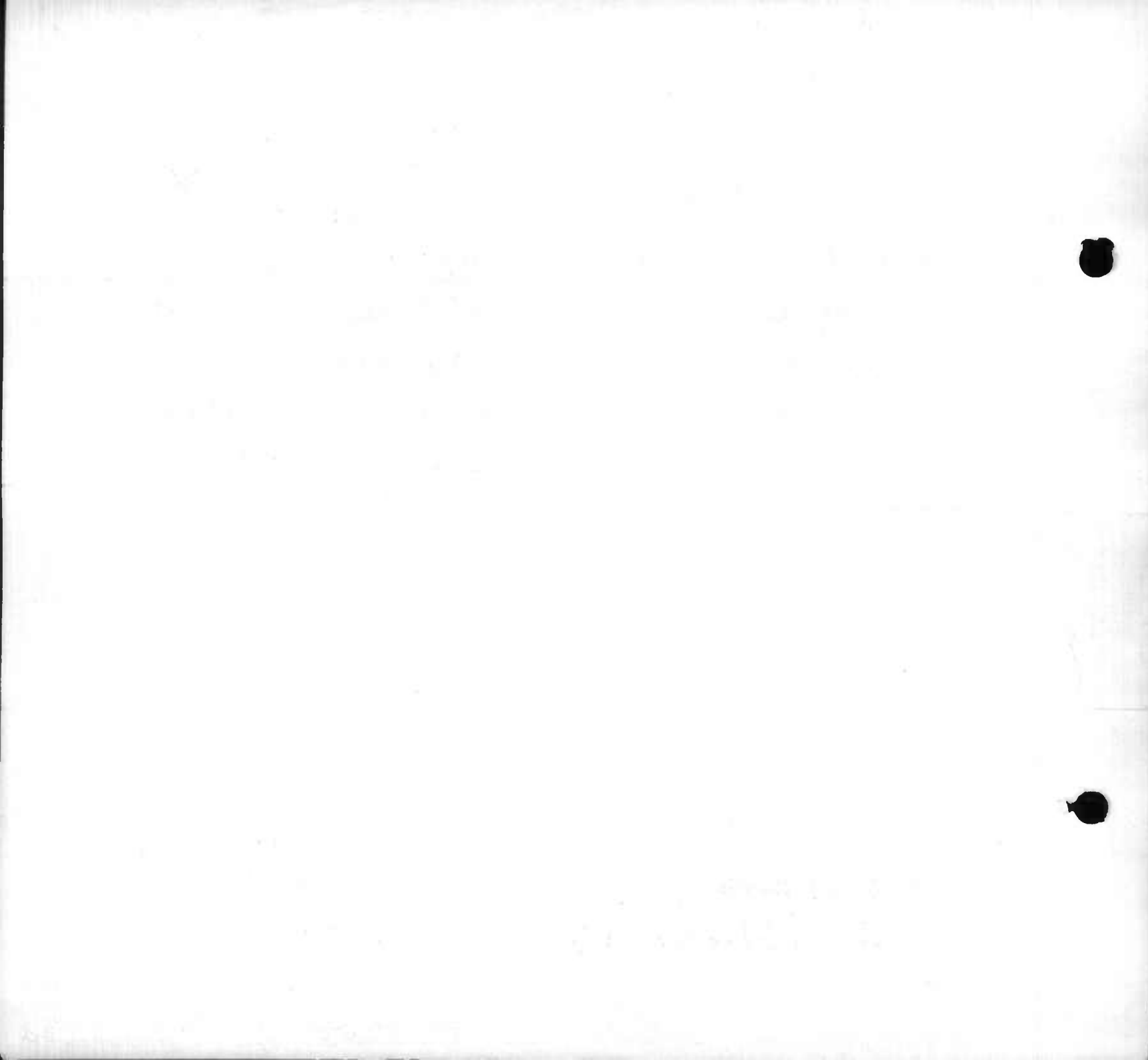
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3933	
<div style="display: flex; justify-content: space-between;"> S-200 70 3933 5-200 70 3933 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) RACHAEL SACHS			2. DATE AND HOUR OF DEATH 4/12/70 11¹⁵ A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 2755		
FULL NAME OF HOSPITAL OR INSTITUTION 2310 SULGRAVE AVE 00			C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 2310 Sulgrave Ave		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept 1986	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months Ooys If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Lith		12. CITIZEN OF WHAT COUNTRY? USA
10B. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME Hyman			14. MOTHER'S MAIDEN NAME Bayle		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Mary Goben
					ADDRESS Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 1957 01			CAUSE OF DEATH Intra-abdominal malignancy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19/89 to April 12 1970 , that (I) (we) last saw the deceased alive on April 11 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Seymour H. Rubin, M.D.				23B. DATE SIGNED 4/13/70	
23C. PHYSICIAN'S NAME (Type) Seymour H. Rubin, M.D.				23D. ADDRESS 5415 Park Heights Dr	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/13/70		24C. NAME OF CEMETERY or CREMATORY Ohef Yachor	
24D. LOCATION Balto		24E. LOCATION (City, town, or county) (State) Md			
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Seymour Lewis 2509 9610 Rensselaer Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-560		70 3934		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3934	
1. NAME OF DECEASED (Type or Print) Robert Winer				2. DATE AND HOUR OF DEATH 4/13/70 12:10 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 1/2 Sinai Hosp				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1/2 Sinai Hosp				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5717 Rubin Ave.							
5. SEX Male	6. RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/93	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Repair		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Meyer				14. MOTHER'S MAIDEN NAME Bluma			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 219-30-9836		17. INFORMANT Samuel Winer		ADDRESS 6822 Pemberton Dr	
18. 410.9 I CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. followed by Dr. E. Kallins							
23A. SIGNATURE Victor S. Schneider, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Victor S. Schneider M.D.				23D. ADDRESS Sinai Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/70		24C. NAME OF CEMETERY OR CREMATORY Workmen Circle		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Sylvan Lewis		ADDRESS 2509 9610 Reisterstown Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 3935		REG. NO. 70 3935	
BIRTH NO. 70 3935				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Rhoda Mary Bullock</i>				2. DATE AND HOUR OF DEATH <i>9 April 1970 19:16 P M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>1305</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Union Memorial Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>729 Bay St.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>03-29-03</i>	9. AGE (In years last birthday) <i>68</i>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Water Ridgely</i>				14. MOTHER'S MAIDEN NAME <i>Sadie White</i>			
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) <i>-</i>		16. SOCIAL SECURITY NO. <i>215-32-1866</i>		17. INFORMANT <i>Hospital Chart</i>		ADDRESS	
18. <i>431.9 I</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Intra-cerebral hemorrhage</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4-08 1970</i> to <i>4-09 1970</i> that (I) (we) last saw the deceased alive on <i>4-09 1970</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>M. Cepeda M.D.</i>				23B. DATE SIGNED <i>9 April 1970</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>M. Cepeda</i>				23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>4-13-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Balto National</i>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 14 1970</i>		25B. NAME OF REGISTRAR <i>John E. ...</i>		25C. FUNERAL DIRECTOR <i>Paul E. ...</i>		ADDRESS <i>3115 Chestnut Ave</i>	

John Memorial Hospital

F W

Walter R. Kelly

257 Bay St.

San Francisco

MA

257 Bay St.

Hospital Care

San Francisco

W. R. Kelly

257 Bay St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

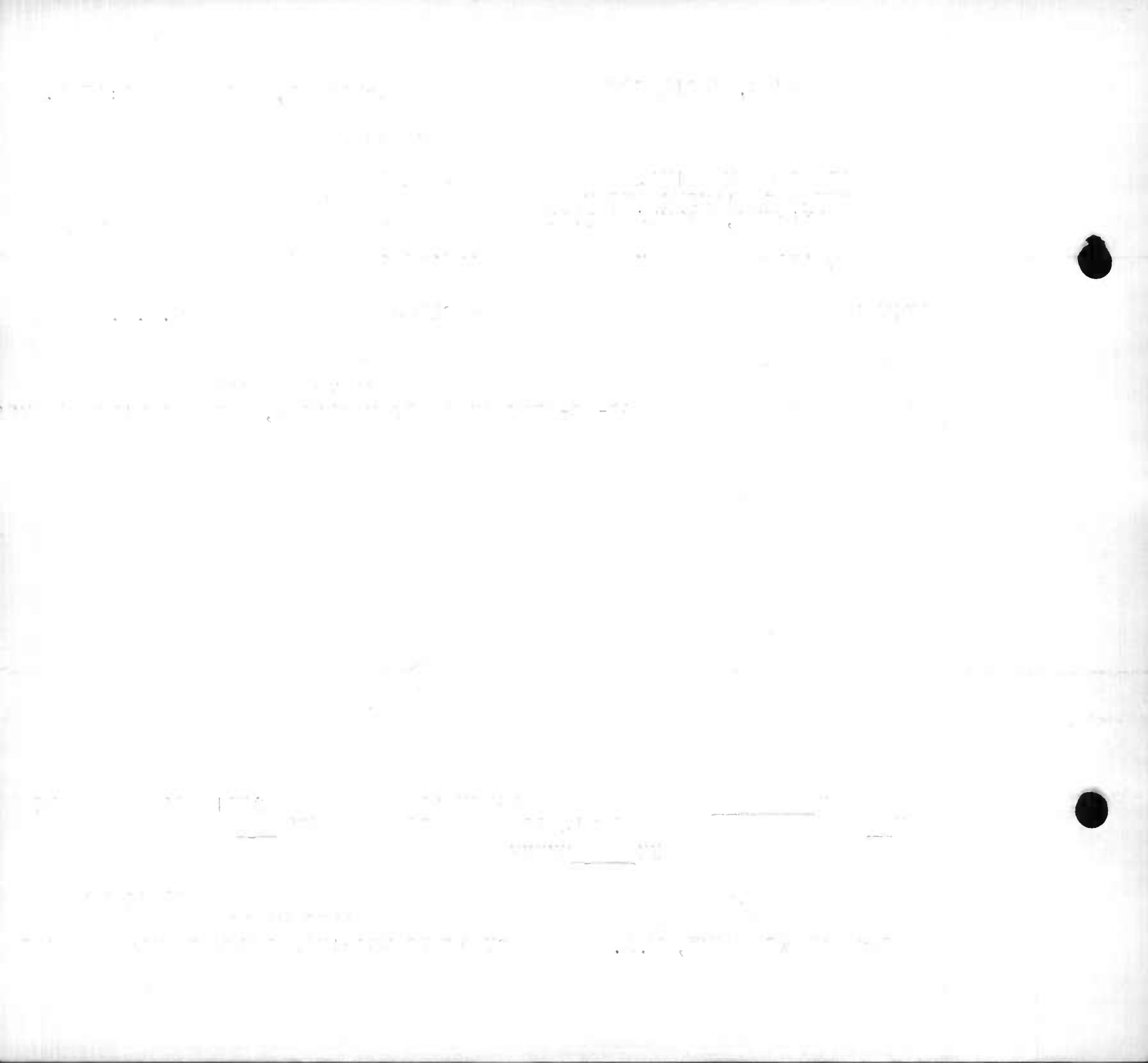
M-326		70 3936		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3936	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) METZGER, MYAQUE TREN				6 PM 4/11/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
43 South Balt: General Hospital				MARYLAND		2302	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1532 S. Charles Street Balt.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7/12/99		70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSE WIFE						MD	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Gilbert F.				MARTHA Michael			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				216-10-27		4B Gilbert Metzger Above Address	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Respiratory arrest			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				(B) ASCVD, Diabetes Mellitus			
				(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 3/22/70 19 to 4/11/70 19 that (I) (we) last saw the deceased alive on 6 PM 4/11/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dhanbir S. Saluja MD				4/11/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DHANBIR S. SALUJA				South Baltimore GENERAL Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-15-70		Glen Haven Cem.		Glen Burnie AA MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 14 1970		Robert E. Saluja MD		McGilly		730 E. Fort Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200 70 3937 BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 70 3937	
1. NAME OF DECEASED (Type or Print) BUSH, CECIL FOX			2. DATE AND HOUR OF DEATH APRIL 13, 1970 1:15 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5902 St. Mary St. - 21207		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/83	9. AGE (in years last birthday) 86	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN			10B. KIND OF BUSINESS OR INDUSTRY B & O R.R.		11. BIRTHPLACE (State or foreign country) ENGLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Adam Bush		
14. MOTHER'S MAIDEN NAME Theresa ?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		
16. SOCIAL SECURITY NO. 705-05-6777			17. INFORMANT BALTO MD 21229 ADDRESS ST AGNES HOSPITAL, CATON & WILKENS AVES		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Heart Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 23 19 70 to APRIL 13 19 70 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 13 19 70 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE J. Mung... MD DEGREE			23B. DATE SIGNED 04/13/70		23C. PHYSICIAN'S NAME (Type) JESADA MUANGSOMBUT M.D. DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/16/70		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.
24D. LOCATION (City, town, or county) Baltimore Md.			24E. LOCATION (State) Md.		
25A. DATE REC'D BY HEALTH DEPT. APR 14 1970			25B. NAME OF REGISTRAR E. Bailey, M.D.		25C. FUNERAL DIRECTOR John J. Cowan & Son Inc. ADDRESS Balto Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3938		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3938	
1. NAME OF DECEASED (Type or Print) H. EDWARD KRAHL			2. DATE AND HOUR OF DEATH 3-28-70 9:15 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 EDGEWOOD NURSING HOME			A. STATE Maryland B. COUNTY 2778		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 821 E. Belvedere Ave.		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-81	9. AGE (In years last birthday) 88	10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail carrier			10B. KIND OF BUSINESS OR INDUSTRY U.S. Post office		11. BIRTHPLACE (State or foreign country) Pittsburg Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Henry J. Krahl		
14. MOTHER'S MAIDEN NAME UNKNOWN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) NO		
16. SOCIAL SECURITY NO. 198-361194T			17. INFORMANT MRS GRACE KRAHL		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.91x/85x			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SECONDS		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) GENERALIZED ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF: ? yrs		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) CARCINOMA OF PROSTATE ? yrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-28 1970 to 3-28 1970 that (I) (we) last saw the deceased alive on 3-28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frederick J. Vollmer M.D.				23B. DATE SIGNED 3-28-70	
23C. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER M.D.				23D. ADDRESS 6100 YORK RD, BALTIMORE, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/3/70		24C. NAME OF CEMETERY or CREMATORY St Paul's	
24D. LOCATION (City, town, or county) (State) Pittsburg Pa.		25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Wm. J. Tickner & Sons		25D. ADDRESS		25E. ADDRESS	



70 3939

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3939

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLARA SPURRIER		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> 4/12/70		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD 4- 12 1970 6:15 P. M.		Month Day Year Hour	
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12/28/1891		10. AGE (In years last birthday) 78		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alfred W. Watkins		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Addie G. Becraft		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 219-22-9090	
18. INFORMANT Mrs. J. Crem Cook		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Septic shock complicating multiple traumatic injuries		20. DATE OF OPERATION 2	
21. AUTOPSY? (Yes or No) yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Inter. of S.W. Blvd. and Old Sulphur Springs Rd.	
24. TIME OF INJURY (APPROX.) 2-2-70		25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		26. HOW DID INJURY OCCUR? Passenger in auto-auto collision.	
27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. ACTUAL EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		29. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
30. DATE REC'D BY HEALTH DEPT. APR 15 1970		31. NAME OF REGISTRAR Robert E. Fisher, M.D.		32. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave., 21229	
33. BURIAL CREMATION, REMOVAL (Specify) Burial		34. DATE 4/16/70		35. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
36. LOCATION (City, town, or county) Baltimore, Maryland		37. DATE OF OPERATION 2		38. CONDITION FOR WHICH OPERATION WAS PERFORMED	

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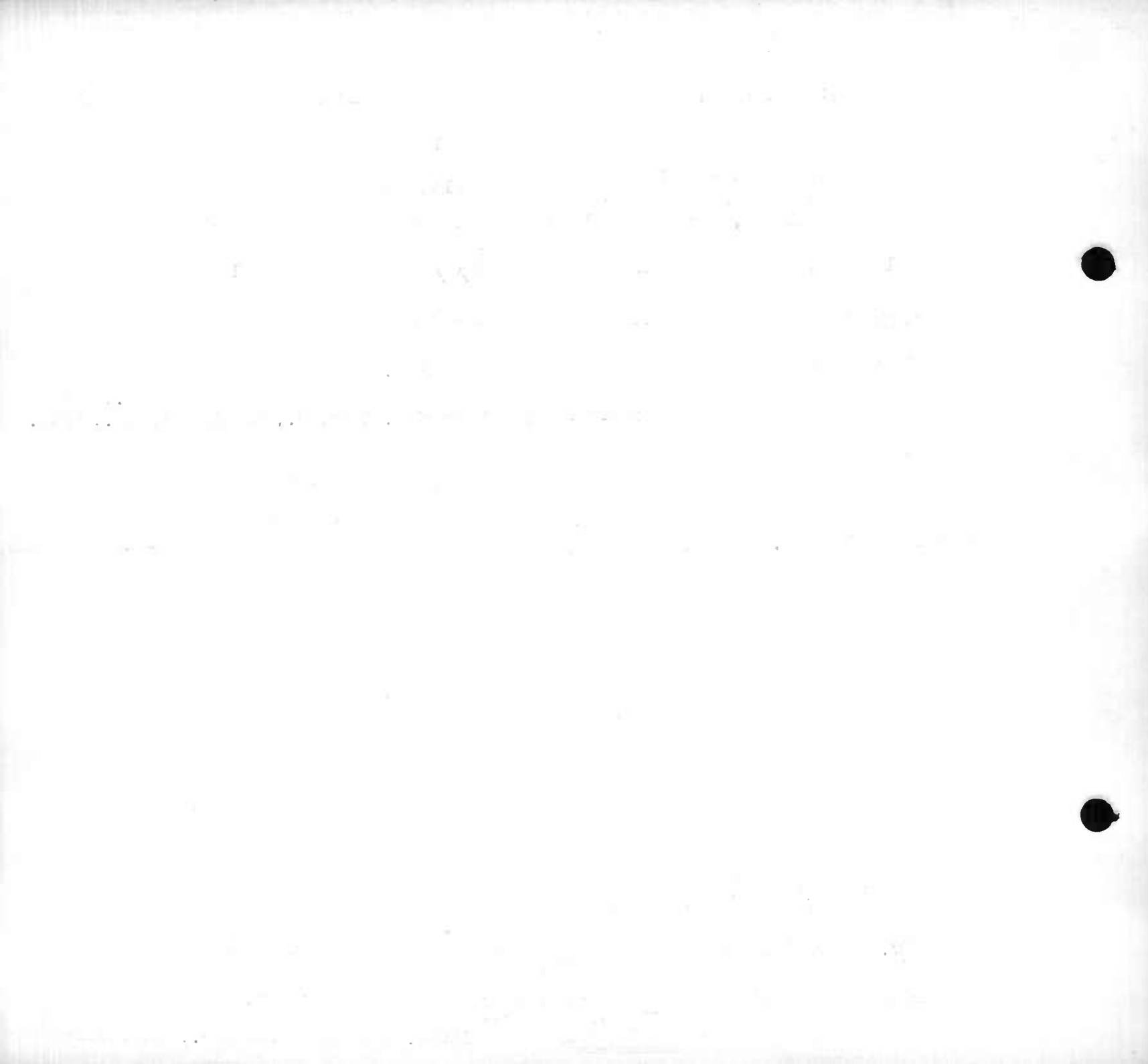
10/10/23

10/10/23

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

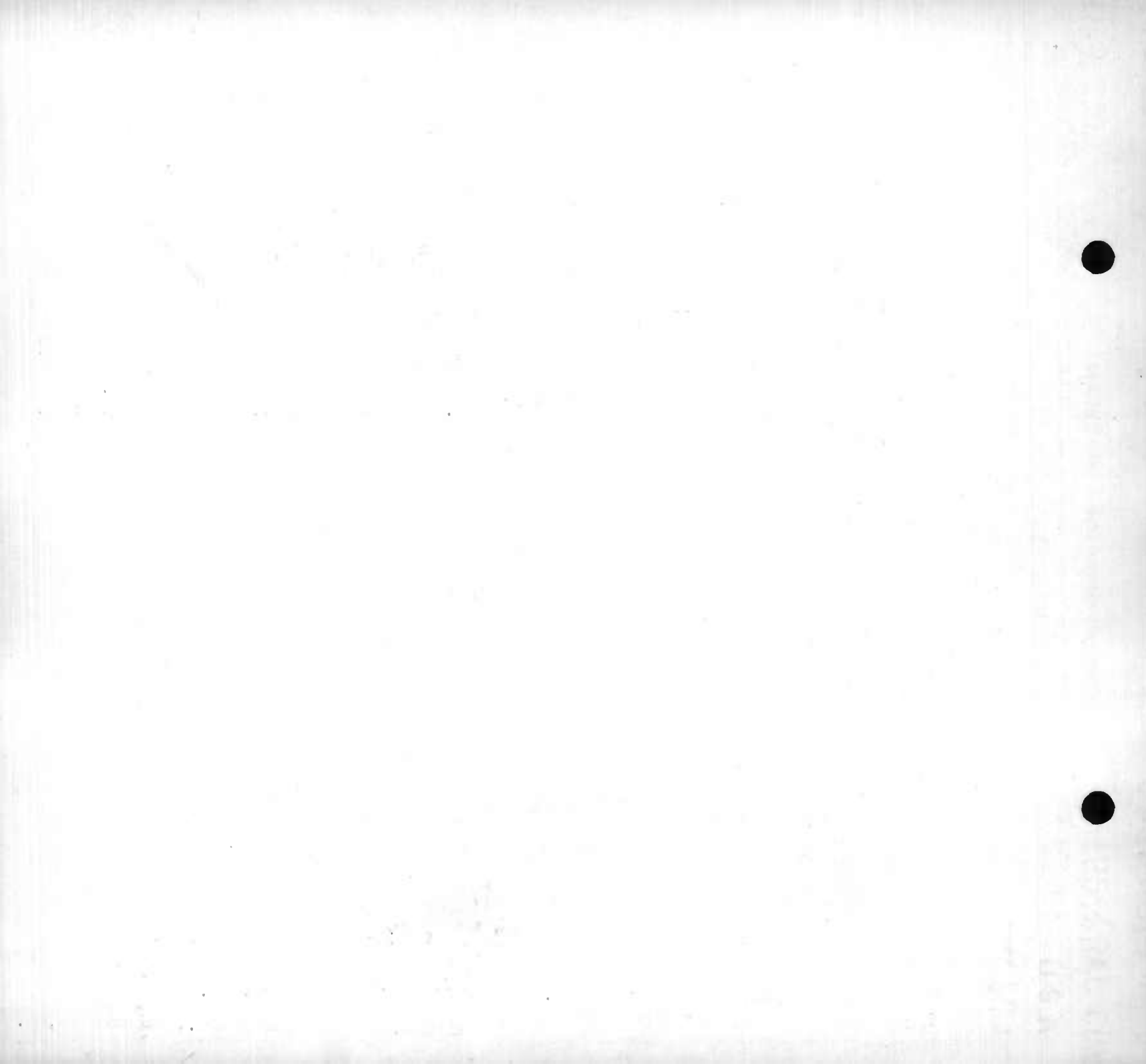
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3940	
BIRTH NO. 70 3940		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Edith N. Hagen</u>			2. DATE AND HOUR OF DEATH <u>4-12-70</u> <u>11:58</u> <small>A.M.</small>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 St. Agnes Hospital</u> <u>Caton & Wilkens Avenue</u> <u>Baltimore, Maryland 21229</u>			A. STATE <u>Maryland</u> B. COUNTY <u>20-08</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4010 Walrad Street 21229</u>		
5. SEX <u>Female</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/6/88</u>	9. AGE (in years last birthday) <u>71</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Henry Hoff</u>		
14. MOTHER'S MAIDEN NAME <u>Annie E.</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>212-28-8727</u>			17. INFORMANT <u>Leonard C. Zake, Sr., 224 Ridgeway Rd., Balto.</u>		
18. <u>4/12/21</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>A.S.C.V.D.; type tension</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>4/12/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19 58</u> to <u>4/12</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3/2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edgar Williamson</u>				23B. DATE SIGNED <u>4/13/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Edgar Williamson</u>				23D. ADDRESS <u>5550 Baltimore National Pike</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>4/15/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Ave., Catonsville</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

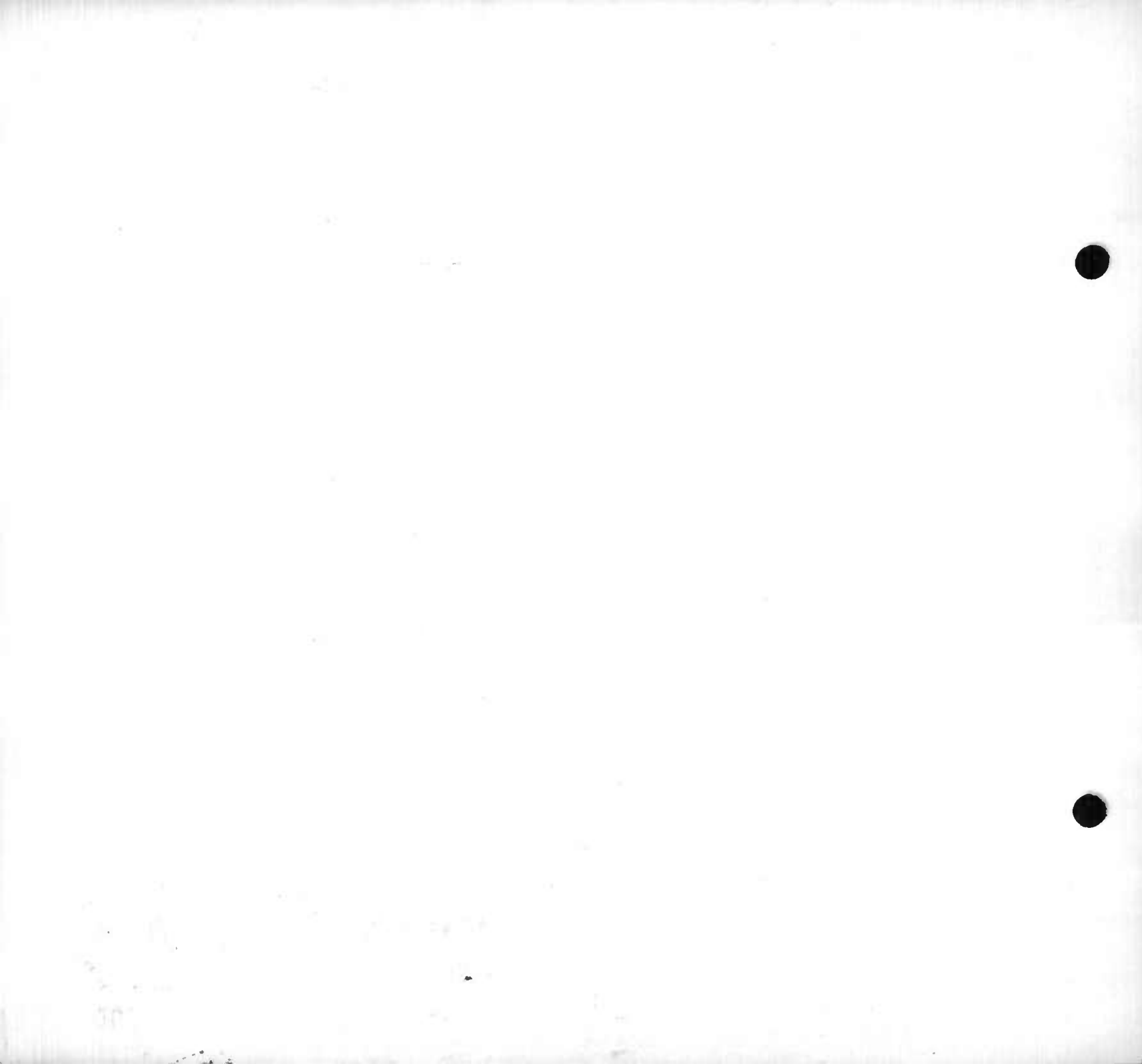
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3941	
BIRTH NO. 70 3941		FABRI		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SARINA FABRI		2. DATE AND HOUR OF DEATH 4/11/70 10:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Luthanan Hosp. of Md. Inc.		C. CITY OR TOWN BRIARCLIFF		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 730 Ashmunton St. Balto. 21216		E. STREET AND NUMBER 4815 Briarcliff Rd. Balto. # 29			
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/22/1914	9. AGE (In years last birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ampelio Salvini		14. MOTHER'S MAIDEN NAME Antoinetta	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217 328614		17. INFORMANT Mrs. Jean Iannatuono, 808 Cooks Lane, Balto., Md. 21229	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute coronary a. occlusion (B) arteriosclerotic cardiovascular dis. chronic DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Recent	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elmo M. Gayoso M.D.		23B. DATE SIGNED 4/12/70		23C. PHYSICIAN'S NAME (Type) Elmo M. Gayoso	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 4/15/70		24C. NAME OF CEMETERY or CREMATORY Lorraine Pk. Mausoleum	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Lorraine Pk. Mausoleum	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., Catonsville, Md.		25D. ADDRESS Luthanan Hosp. of Md. Inc. 730 Ashmunton St. Balto. 21216		25E. ADDRESS Witzke, 1630 Edmondson Ave., Catonsville, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

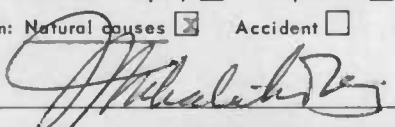
B-524 70 3942		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3942	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Arthur Bengal		4-10-70 4:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 7 MERCY HOSPITAL		A. STATE Md		B. COUNTY 11-02	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 506 Cathedral St			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-15-10	9. AGE (in years last birthday) 59	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE ASCENDING acute MI (myocardial) DUE TO, OR AS A CONSEQUENCE OF: (B) Emphysema, severe DUE TO, OR AS A CONSEQUENCE OF: (C) Cushing's aid 20 to Steroid Rx.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs. YEARS YEARS	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/67 to 3/70 that (I) (we) last saw the deceased alive on 3-15-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE Philip J. Moore		23B. DATE SIGNED 4/10/70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-14-70		24C. NAME OF CEMETERY or CREMATION JOHNS HOPKINS MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3943

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JUAN MENDEZ				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 2 28 70 Hour 10:00 a.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 32 S. Broadway Apt. 5				3. DATE PRONOUNCED DEAD Month Day Year Hour February 28, 1970 10:00 a.					
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH				10. AGE (In years last birthday) 40?		11. BIRTHPLACE (State or foreign country)			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.			
18. INFORMANT				ADDRESS					
19. 304.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH Drug overdose (several) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE  M.D. EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>								DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-13-70		24C. NAME OF CEMETERY or CREMATOR		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR		ADDRESS MORTUARY SERVICE - BCHD			

11/5/70 - Letter from M.E.O.

18 e.

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3-530 70 3944

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3944

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Sneed		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 3 19 70 5:30 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 3 19 70 5:30 p. M.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 61		E. STREET AND NUMBER 578 Laurence St. LARKENS ST	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: Laennec's cirrhosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/20/70			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-13-70	
24C. NAME OF CEMETERY or CREMATOR		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	

VS 151-REV. 7/1/68

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHO

[Faint, illegible handwritten notes]

1

T-455

3945

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3945

1. NAME OF DECEASED (Type or Print) MARY TILLMAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 1, 1970 Hour 8:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year April 1, 1970 Hour 8:30 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-10		C. CITY OR TOWN Baltimore	
6. SEX Female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) 54	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 345.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED April 2, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-13-70	
24C. NAME OF CEMETERY		24D. ADDRESS (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHO

Letter from M.E.'s office 7-14-70 M.H.

7/16/70 - Epileptic seizure
ME's office via phone
ge

ACADEMY BOND

VALLEY PACIFIC CO.

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3946

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 3946

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ERNEST FERGUSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 10 E. Preston Street		3. DATE PRONOUNCED DEAD Month Day Year Hour March 25, 1970 9:27 P.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10. AGE (In years lost birthday) 41		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER 108 E. Madison ST	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED March 26, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-13-70	
24C. NAME OF CEMETERY		24D. NAME OF REGISTRAR Charles E. Taylor, R.D.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	

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BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3947

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CLARENCE STANT		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour February 24, 1970 8:51 P.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 202			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 10. AGE (In years lost birthday) 69		E. STREET AND NUMBER 117 S. Broadway	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

MEDICAL CERTIFICATION	19. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Fatty Metamorphosis of Liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
	20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no
	22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
	22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
	23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
	ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/25/70
	24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-13-70		24C. NAME OF CEMETERY
	25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCND

VIA AIR MAIL

POSTAGE GUARANTEED

RECEIVED
JAN 10 1941
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3948	
BIRTH NO. S-240 70 3948		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SIEGEL, DORA			2. DATE AND HOUR OF DEATH 4 / 13 / 1970 2.00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2720		
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER 3905 Glenlyle Ave. #15.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/3/1894	9. AGE (in years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME JOSEPH BERKOW			14. MOTHER'S MAIDEN NAME MINNIE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS MR. BERNARD SIEGEL, 6604 BAYTHORNE ROAD #9	
18. 410.9 + 1250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE CEREBROVASCULAR ACCIDENT. DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD MYOC. INFARCTION. DUE TO, OR AS A CONSEQUENCE OF: (C) DIABETES MELLITUS.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			DIABETES MELLITUS.		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/24 1970 to 4/13 1970 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/13 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 4/13/70	
23C. PHYSICIAN'S NAME (Type) ANDREAS A. PETSAS M.D.		23D. ADDRESS SINAI HOSPITAL OF BALTO.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-14-70		24C. NAME OF CEMETERY OR CREMATORY MOS ES MONTIFLORE	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 15 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-256 70 3949		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3949	
1. NAME OF DECEASED (Type or Print) MYRON BUCKNER				2. DATE AND HOUR OF DEATH APRIL 13, 1970 2:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Howard C. CITY OR TOWN ELLICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4416 COLUMBIA ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-1914	9. AGE (In years last birthday) 56	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY DENTAL LABORATORY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SIMON BUCKNER				14. MOTHER'S MAIDEN NAME SARAH ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. LYDIA BUCKNER, 4416 COLUMBIA RD., MD.			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Probable Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Anteriosclerotic CVD E (C) 2 previous Myocard. Infarcts 13 yrs. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH moments 13 yrs.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/30 19 57 to present 19 70 that (I) (was) last saw the deceased alive on 4/7 19 70 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did not) view the body after death.							
23A. SIGNATURE J. Elliott Levi, M.D.				23B. DATE SIGNED 4/13/70		23C. PHYSICIAN'S NAME (Type) J. ELLIOTT LEVI	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-14-70		24C. NAME of CEMETERY or CREMATORY HEBREW FRIENDSHIP		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

1-10-1913

MENTAL DEPT. HOSP. BALTIMORE, MARYLAND

26 JAN

26 JAN

MR. LLOYD STOKES, M.D.

J. ELLIOTT LEWIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 3950
H-541 70 3950		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EZRA HIMELFARB		2. DATE AND HOUR OF DEATH 4/12/70 13:15 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2714			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4401 ROLAND AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 03/04/15	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY APPLIANCE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL HIMELFARB		14. MOTHER'S MAIDEN NAME ANNA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. MARJORIE HIMELFARB, 500 W. UNIVERSITY PKWY.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) INTRABDOMINAL HEMORRHAGE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MULTIPLE RECURRENT INTESTINAL FISTULAE (B) DUE TO, OR AS A CONSEQUENCE OF: CROHN'S DISEASE (C) GRAM NEGATIVE / FUNGAL SEPTICEMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS 30+ YRS 10 DAYS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4/12 19 70 to 4/12 19 70 , that (I) (we) last saw the deceased alive on 4/12 19 70 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert S. Weinberg M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/12/70	
23C. PHYSICIAN'S NAME (Type) ROBERT S. WEINBERG M.D.		23D. ADDRESS Hopkins Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-14-70		24C. NAME OF CEMETERY or CREMATORY PARKWOOD	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN RD.	

Johns Hopkins

APPLIANCE
SOLUBLE WELFARE

INTERNAL COMMUNICATIONS
UNIT

~~XXXXXXXXXXXXXXXXXXXX~~

Give negative from Service in 0412
CROSS'S DISC 2 30 + 142
Positive Record in 0412 2 1412

Robert S. Williams M.D.
4/15/50

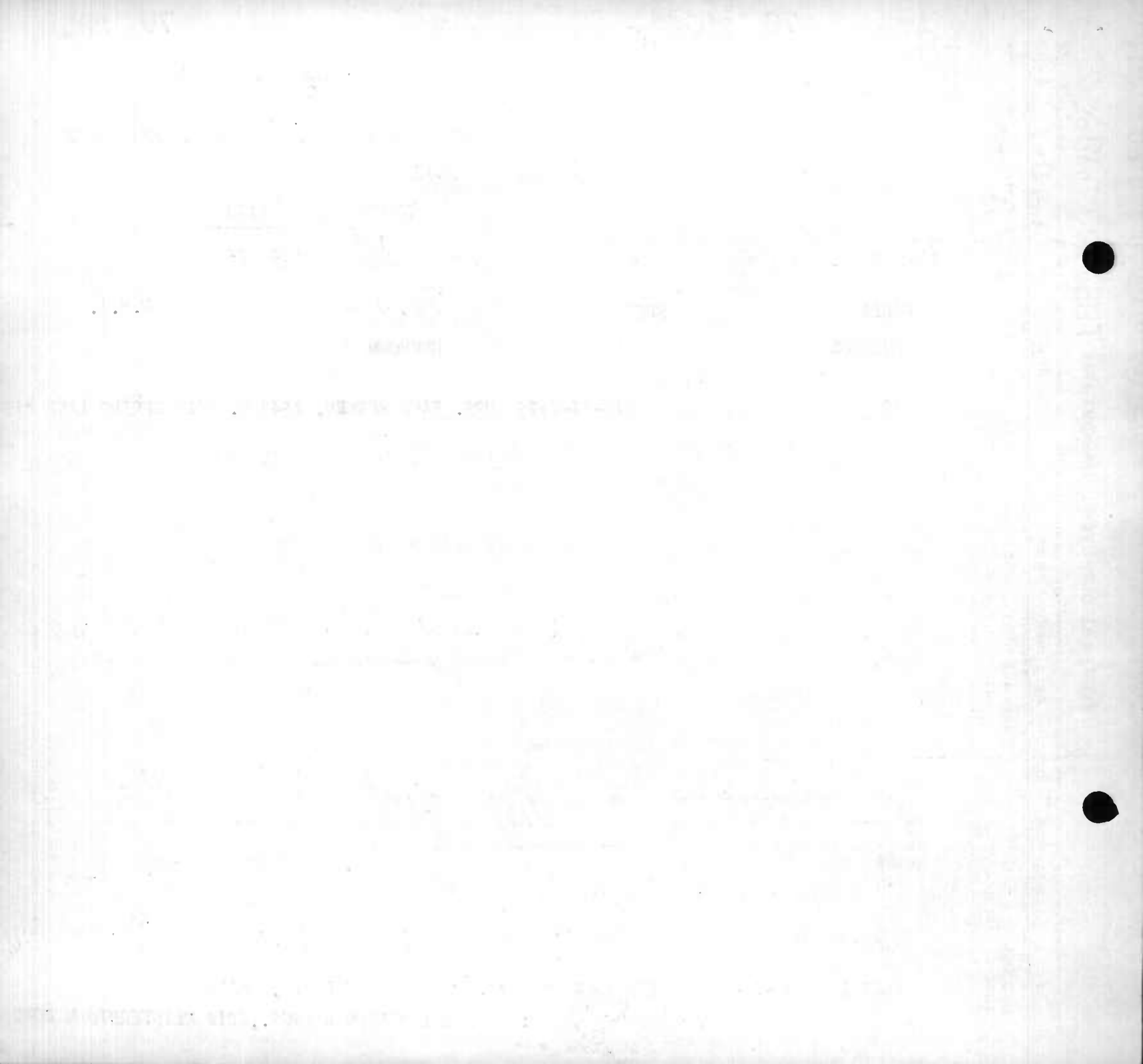
10
X

4/15/50

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3951	
I-256 70 3951		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LOUIS ISMART		2. DATE AND HOUR OF DEATH April 12 1970 6 PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO.		5. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Jewish Convalescent Home		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 3133 OAKFORD AVENUE	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-1894	9. AGE (In years last birthday) 76	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER		10B. KIND OF BUSINESS OR INDUSTRY SHOP		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-01-2870		17. INFORMANT MRS. FAYE SERKEN, 2540 W. COLD SPRING LANE #15	
18. 437.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pulmonary Emphysema		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/12/1970 to 4/12/1970 , that (I) (we) lost saw the deceased alive on 4/12/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Marvin Goldstein, M.D.		23B. DATE SIGNED 4/12/70		23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN, M.D.	
23D. ADDRESS 6001 PARK HIGHTS AVE. BALTO., MD		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-14-70	
24C. NAME OF CEMETERY or CREMATORY BETH HAMEDROSH HAGODOL		24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 15 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS	

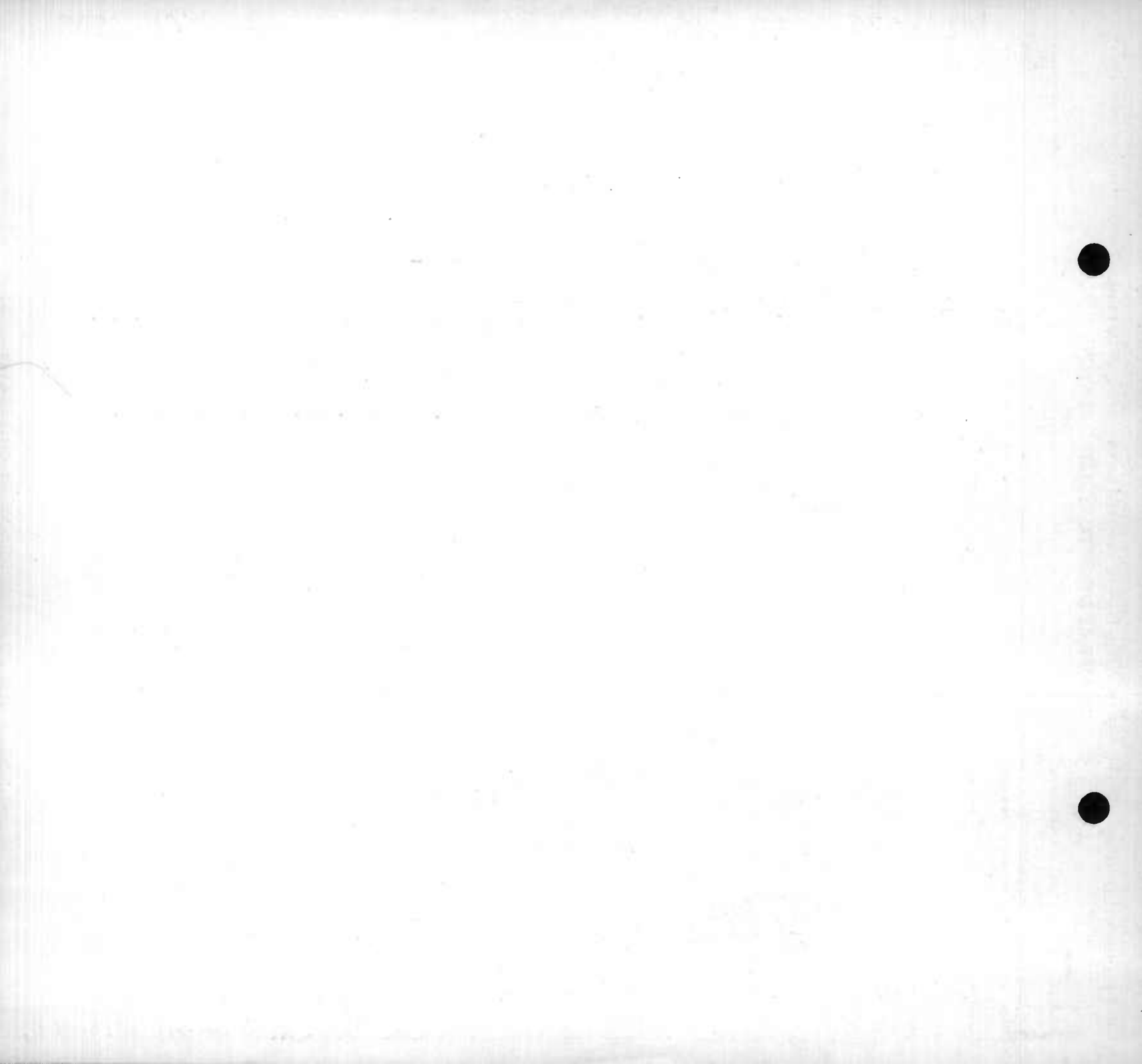


BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3952	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
BIRTH NO. <u>D-263</u>					
1. NAME OF DECEASED (Type or Print) <u>PATRICIA DOUGHERTY</u>			2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> Missing <u>6-25-69</u> ? <u>Unk.</u> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>REAR OF 5119 BELAIR ROAD</u>			3. DATE PRONOUNCED DEAD Month Day Year <u>April 7, 1970</u> 7:00 P. M.		
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY					
6. SEX <u>Female</u>	7. RACE <u>White</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <u>Dec. 29, 1933</u>	10. AGE (In years last birthday) <u>36</u> <u>37</u>	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER <u>800 E. Fort Ave.</u> <u>322-N-Exeter-Street-</u> <u>24-04</u>		
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Archie Dougherty</u>		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Maid</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	15. MOTHER'S MAIDEN NAME <u>Freda Paddy</u>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO.	18. INFORMANT <u>Robt. Dougherty</u> ADDRESS <u>800 E. Fort Ave.</u>		
19. <u>79691</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			CAUSE OF DEATH <u>Undetermined due to post-mortem decomposition</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>yes</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <u>Ronald N. Kornblum</u> M.D. EXAMINER'S NAME (Type) <u>Ronald N. Kornblum, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/10/70</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-14-70</u>	24C. NAME of CEMETERY or CREMATORY <u>Glen Haven</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie, A. A. Co. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Mc Gully 130 E. Fort Ave.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-523		70 3953		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3953	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Austin L. Jenkins, SR.</u>			
2. DATE AND HOUR OF DEATH <u>4/10/70 5:30 AM</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>THE JOHNS HOPKINS HOSPITAL</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>• MARYLAND</u> B. COUNTY <u>CECIL</u>				5. CITY OR TOWN <u>ELKTON</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>215 N. HIGH STREET</u>				6. DATE OF BIRTH <u>10-30-94</u>			
7. AGE (In years last birthday) <u>75</u>				8. CITIZEN OF WHAT COUNTRY? <u>W.S.A.</u>			
9. SEX <u>MALE</u>				10. RACE <u>WHITE</u>			
11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Penn. Railroad Co.</u>			
13. FATHER'S NAME <u>FRANK JENKINS</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE NESBITT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>717-09-26204</u>			
17. INFORMANT <u>Mrs. Linda A. Jenkins, Elkton, Md.</u>				ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cordic arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Bl loss</u> <u>Ruptured Aortic Aneurysm</u> <u>ASVD?</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>				19A. DATE OF OPERATION <u>4/10</u>			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Aortic Aneurysm</u>				20A. AUTOPSY? (Yes or No) <u>Yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/10/70</u> 19 to <u>4/10/70</u> 19, that (I) (we) last saw the deceased alive on <u>4/10/70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <u>H. Fee MD</u>			
23B. DATE SIGNED <u>4/10/70</u>				23C. PHYSICIAN'S NAME (Type) <u>H. Fee MD</u>			
23D. ADDRESS <u>Johns Hopkins Hospital</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>4/13/70</u>				24C. NAME OF CEMETERY or CREMATORY <u>Elkton Cemetery</u>			
24D. LOCATION <u>Elkton, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>				25C. FUNERAL DIRECTOR <u>Wickham & Sons Funeral Home, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

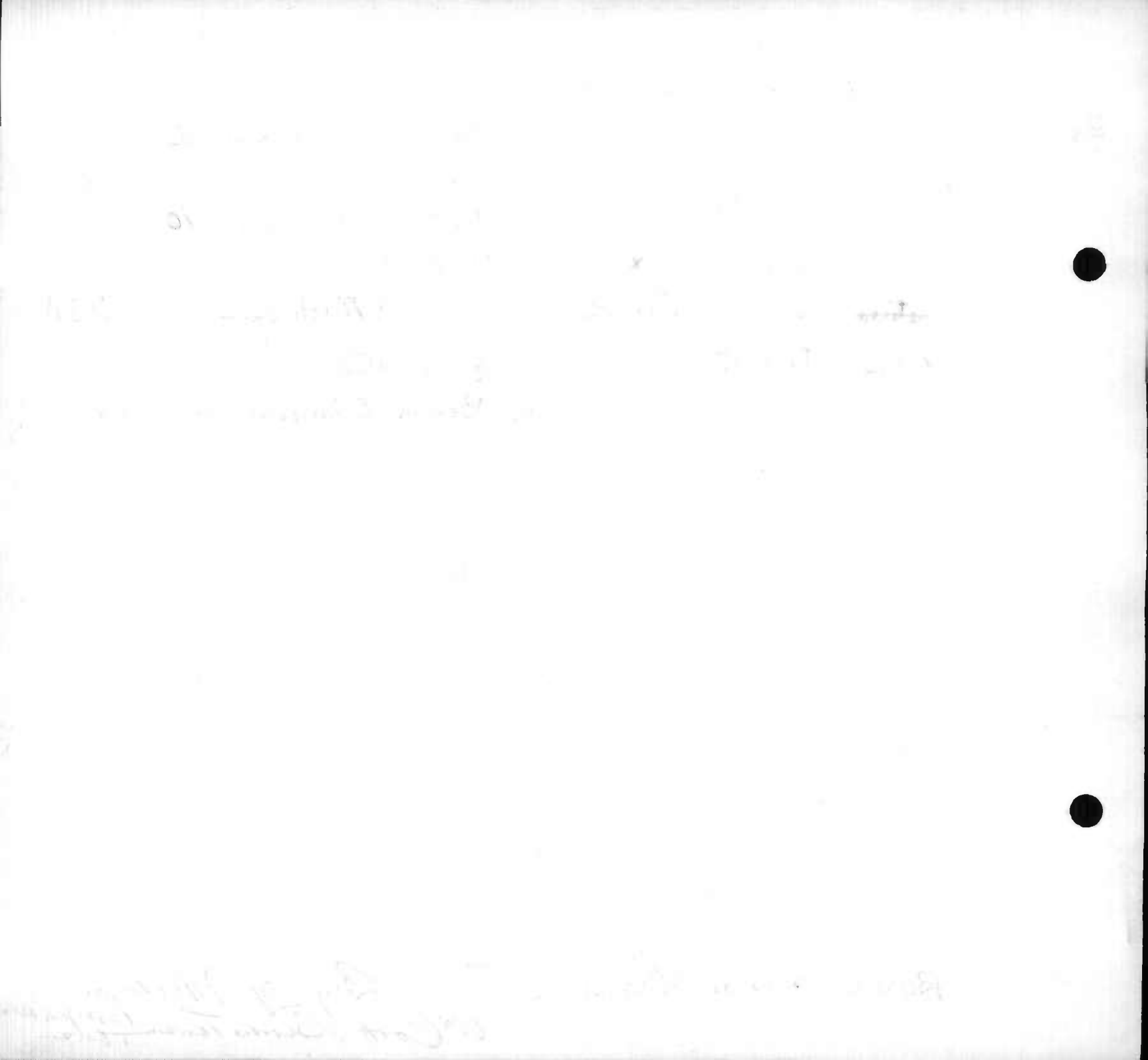
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 3954		CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3954	
1. NAME OF DECEASED (Type or Print) Helsel, Miriam Irene		2. DATE AND HOUR OF DEATH 4/11/70 11:31 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY ELKton			
FULL NAME OF HOSPITAL OR INSTITUTION Univ. of Maryland Hospital		C. CITY OR TOWN ELKton		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 14 Joseph Gallagher St. 57-21			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/09	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Raymond Reed			
14. MOTHER'S MAIDEN NAME Beulah Beckley		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 170-44-9192		17. INFORMANT Chart			
18. 394.01 + 230.9		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatic coma			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: following mitral valve replacement			
		(C) Rheumatic heart disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mild					
19A. DATE OF OPERATION 3/24/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED mitral valve disease		20A. AUTOPSY? (Yes or No) Y	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost soul the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Shigen		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) E. Shigen		23D. ADDRESS Univ. Hosp		23E. 225 Green St., Balt. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-15-70		24C. NAME OF CEMETERY or CREMATORY Rede Church Cemetery	
24D. LOCATION (City, town, or county) (State) Marion Twp., Berks Co., Pa.		25A. DATE REC'D BY HEALTH DEPT. APR 15 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR James Hartenstein, New Freedom, Pa.			

FUNERAL DIRECTOR: IMPORTANT

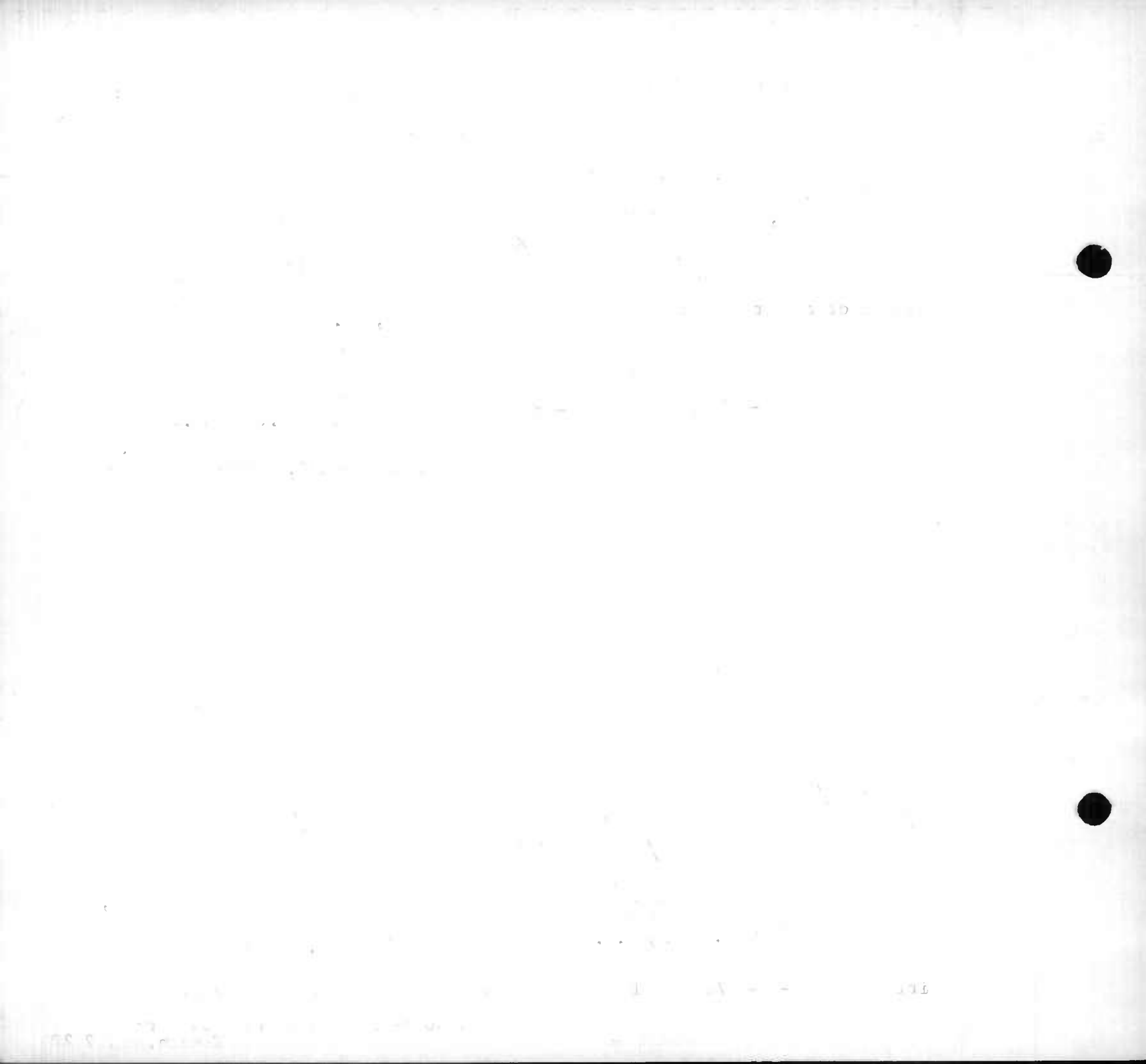
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-300		70 3955		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3955	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Bessie M. Scott</u>				2. DATE AND HOUR OF DEATH <u>4-13-70 at 7:40 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				M.	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon. Secours. Hosp.</u>				A. STATE <u>MD</u>				B. COUNTY <u>Howard Co</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2025 W. Fayette St. Balto 23-Md</u>				C. CITY OR TOWN <u>Ellicott City</u>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>				6. RACE <u>white</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Active Sales</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Flour</u>				8. DATE OF BIRTH <u>05/01-84</u>	
13. FATHER'S NAME <u>Charles Cuthbert</u>				14. MOTHER'S MAIDEN NAME <u>Jane Carter</u>				9. AGE (In years last birthday) <u>85</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>367-01-3785</u>				17. INFORMANT <u>Beulah E. Sanner. same as #14</u>	
18. <u>4-13-70</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cerebellar hemorrhage</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>					
19. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive + arterosclerotic Ht.</u>				(B) <u>years</u>	
20. <u>release</u>				(C) <u>release</u>					
MEDICAL CERTIFICATION				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?				20A. AUTOPSY? (Yes or No) <u>YES</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
22. I certify that (He) (this hospital) attended the deceased from <u>3-31</u> 19 <u>70</u> to <u>4-13</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4-13</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <u>Sam C. Kerr M.D.</u>				23B. DATE SIGNED <u>4-13-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>IAIN C. KERR</u>				23D. ADDRESS <u>BON SELOURS HOSP. 2025 W. FAYETTE ST BALTO MD 21223</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4-17-70</u>				24C. NAME OF CEMETERY or CREMATORY <u>Greenridge</u>	
24D. LOCATION (City, town, or county) (State) <u>Ray City Michigan</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Wm. Cook & Sons Town</u>				25D. ADDRESS <u>1050 York Rd.</u>					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) MOWERY, William Peter		2. DATE AND HOUR OF DEATH 4/14/70 9:40 A	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 28-34	
5. SEX Male		6. RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/8/04	
9. AGE (In years last birthday) 66		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Work		10B. KIND OF BUSINESS OR INDUSTRY Soap	
11. BIRTHPLACE (State or foreign country) Shamokin, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Mowery		14. MOTHER'S MAIDEN NAME Irene Beechman	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes If yes, give war or dates of service 7/29/42 - 11/4/44		16. SOCIAL SECURITY NO. 160-16-0423	
17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218		ADDRESS	
18. CAUSE OF DEATH 450X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pulmonary Emboli, massive (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION NO 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from April 10th 19 70 to April 14th 19 70 that (1) (we) last saw the deceased alive on April 14th 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE YOUNG E. CHUN, M.D.		23B. DATE SIGNED April 14, 1970	
23C. PHYSICIAN'S NAME (Type) YOUNG E. CHUN, M.D.		23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-18-1970	
24C. NAME OF CEMETERY or CREMATORY Odd Fellows Cemetery		24D. LOCATION (City, town, or county) (State) Shamokin, Penna.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks		ADDRESS Towson, Md. 21204	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

I-650		70 3957		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3957			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Irwin, Miss Georgia Edna</i>				2. DATE AND HOUR OF DEATH <i>4-8-70</i> <i>9P</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>99.C. 52-00</i>							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>91 Keswick - 700 W. 40th ST</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>							
5. SEX <i>F</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>10/30/1900</i> 9. AGE (In years lost birthday) <i>69</i>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Knoxville, Tenn.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Francis M Irwin</i>				14. MOTHER'S MAIDEN NAME <i>Ousley, Hilla</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <i>Keswick Records</i> ADDRESS <i>900 W. 40th ST.</i>			
18. <i>756.6 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>Acute & Chronic Bronchitis</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Osteogenesis Imperfecta</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>Life</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5-14-1962</i> to <i>4-8-1970</i> , that (I) (we) last saw the deceased alive on <i>4-8-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>Aubrey D. Richardson</i>				23B. DATE SIGNED <i>8 April 1970</i>				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type) <i>Aubrey D. Richardson M.D.</i>				23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>REMOVAL</i>				24B. DATE <i>4/8/70</i>				24C. NAME OF CEMETERY OR CREMATORY <i>Johns Hopkins University</i>			
24D. LOCATION (City, town, or county) (State)				25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1970</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			
25C. FUNERAL DIRECTOR <i>Wm. J. Lickel & Sons Inc</i>				25D. ADDRESS <i>North PA AVES</i>							

Keswick - 500m. Holt St

F W

Green water

Two men in IRM

10/30/1900

Green water

Two men in IRM

Keswick - 500m. Holt St

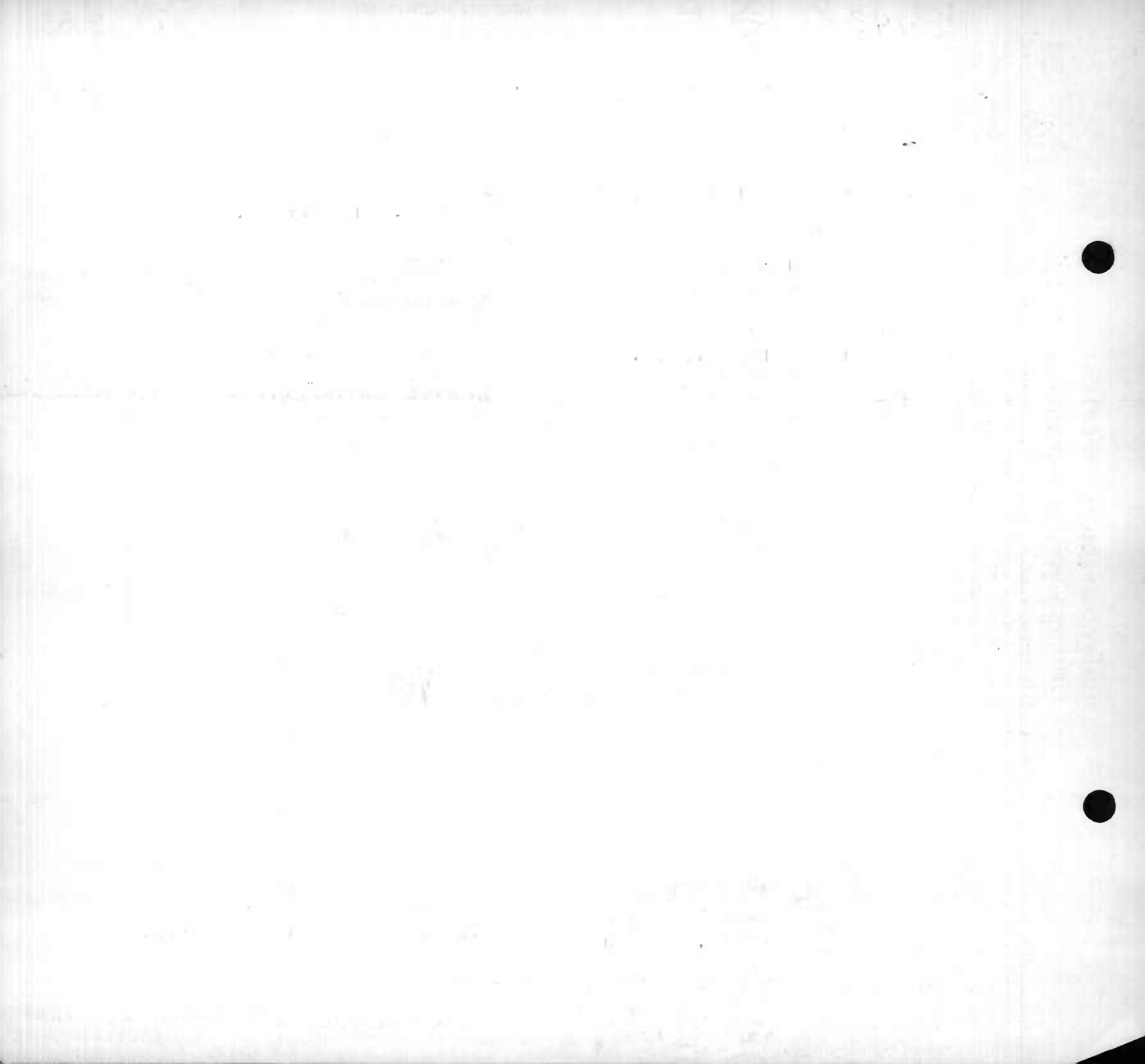
A 2 W

Two men in IRM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3958	
<p>S-143 BIRTH NO. 70-05703 3958</p> <p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center;">BLAINE SHIFFLETT JR.</p>		<p style="text-align: center;">2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;">4-9-70 7:40 PM</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="text-align: center;">THE JOHNS HOPKINS HOSPITAL</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY Baltimore</p> <p>C. CITY OR TOWN RANDALLSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 299 B. LIBERTY RD.</p>			
<p>5. SEX MALE 6. RACE WHITE</p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE</p>		<p>8. B. DATE OF BIRTH 4-2-70 9. AGE (In years last birthday) 7</p> <p>11. BIRTHPLACE (State, or foreign country) BALTIMORE, MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>			
<p>13. FATHER'S NAME BLAINE SHIFFLETT SR.</p> <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>14. MOTHER'S MAIDEN NAME GWENDA MEADOWS</p> <p>16. SOCIAL SECURITY NO. — 17. INFORMANT BLAINE SHIFFLETT SR. ADDRESS 299 B. LIBERTY RD.</p>			
18. 74671 CAUSE OF DEATH					
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE Cardiac arrest</p> <p>(B) Congenital Heart Disease</p> <p>(C) Renal failure</p>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
<p>19A. DATE OF OPERATION 2</p> <p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>20A. AUTOPSY? (Yes or No) Yes</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 4-7 19 70 to 4-9 19 70, that (I) (we) lost saw the deceased alive on 7:40 PM 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Duane W. Ebaugh</p> <p>23C. PHYSICIAN'S NAME (Type) D. DUANE W. EBAUGH</p>				<p>23B. DATE SIGNED 4-9-70</p> <p>23D. ADDRESS THE JOHNS HOPKINS HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL</p> <p>25A. DATE REC'D BY HEALTH DEPT. APR 15 1970</p>		<p>24B. DATE 4/11/70 24C. NAME OF CEMETERY or CREMATORY LAKE VIEW CEMETERY</p> <p>24D. LOCATION (City, town, or county) (State) SYKESVILLE, MARYLAND</p>			
<p>25B. NAME OF REGISTRAR Robert E. Taylor, M.D.</p>		<p>25C. FUNERAL DIRECTOR LORING BYERS ADDRESS 8728 LIBERTY RD. 21133 RANDALLSTOWN</p>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3959	
B-625 70 3959		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		MICHAEL J. BRACKEN		2. DATE AND HOUR OF DEATH	
MICHAEL J. BRACKEN				4-13-70 8 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
No Lutheran Hospital		A. STATE Maryland B. COUNTY Baltimore		28-64	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS	
No Lutheran Hospital		Baltimore		YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		404 SWANN AVE.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-12-1902	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		Minnacord Co.		Westmeath Ireland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Michael J. Bracken		Annie Tracey		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		2-14-20-2219A		Jane Kimmel	
				ADDRESS 546 4 Addison Ter Rd	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.)		CARDIOGENIC SHOCK		MINUTES	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		ACUTE MYOCARDIAL INFARCTION		HOURS	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) ASCVD			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4-13 19 70 to 4-13 19 70, that (I) (we) last saw the deceased alive on 4-13 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Oscar E. Ferdinandini M.D.		4-13-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
OSCAR E. FERNANDINI M.D.		LUTHERAN HOSP. OF MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/16/70		New Cathedral Cem	
				Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 15 1970		Paul E. Juby		Phoebe J. Perry	
				ADDRESS 1608 Hollins St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">H-536 70 3960</h2>		<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2>		<h2 style="margin: 0;">70 3960</h2>	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <u>Joyce Henderson</u>		2. DATE AND HOUR OF DEATH <u>April 14, 1970 @ 7:30 AM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital.</u> ADDRESS OR LOCATION <u>4-21-70</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland.</u> B. COUNTY <u>19-01</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>303 N Calhoun St</u>			
5. SEX <u>7</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-42</u>	9. AGE (In years last birthday) <u>27</u>	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>-None-</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Henderson</u>		14. MOTHER'S MAIDEN NAME <u>Cora Chewing</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>219-38-8778</u>		17. INFORMANT <u>Cora Henderson</u> ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>5-90.01</u>		CAUSE OF DEATH <u>Cardiogenic shock</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Rejection Reaction</u>		<u>5 1/2 weeks</u>	
		(B) <u>Transplanted Kidney 3/6/70</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>Several years</u>	
		(C) <u>Chronic Pyelo & Chronic Glomerulo</u>			
		<u>Multiple surgical A-V shunts</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>3/6/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Renal Transplant</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>4/1/70</u> 19 to <u>4/14/70</u> 19 that (2) (we) last saw the deceased alive on <u>4/14</u> 19 70 and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David J. Picerson</u> MD DEGREE				23B. DATE SIGNED <u>4/14/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>David J. Picerson</u> MD DEGREE				23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-17-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Mem. Park</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. LOCATION (City, town, or county) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Cherry O. Wilson</u> ADDRESS <u>1000 Brantley Ave.</u>	

V.S 153

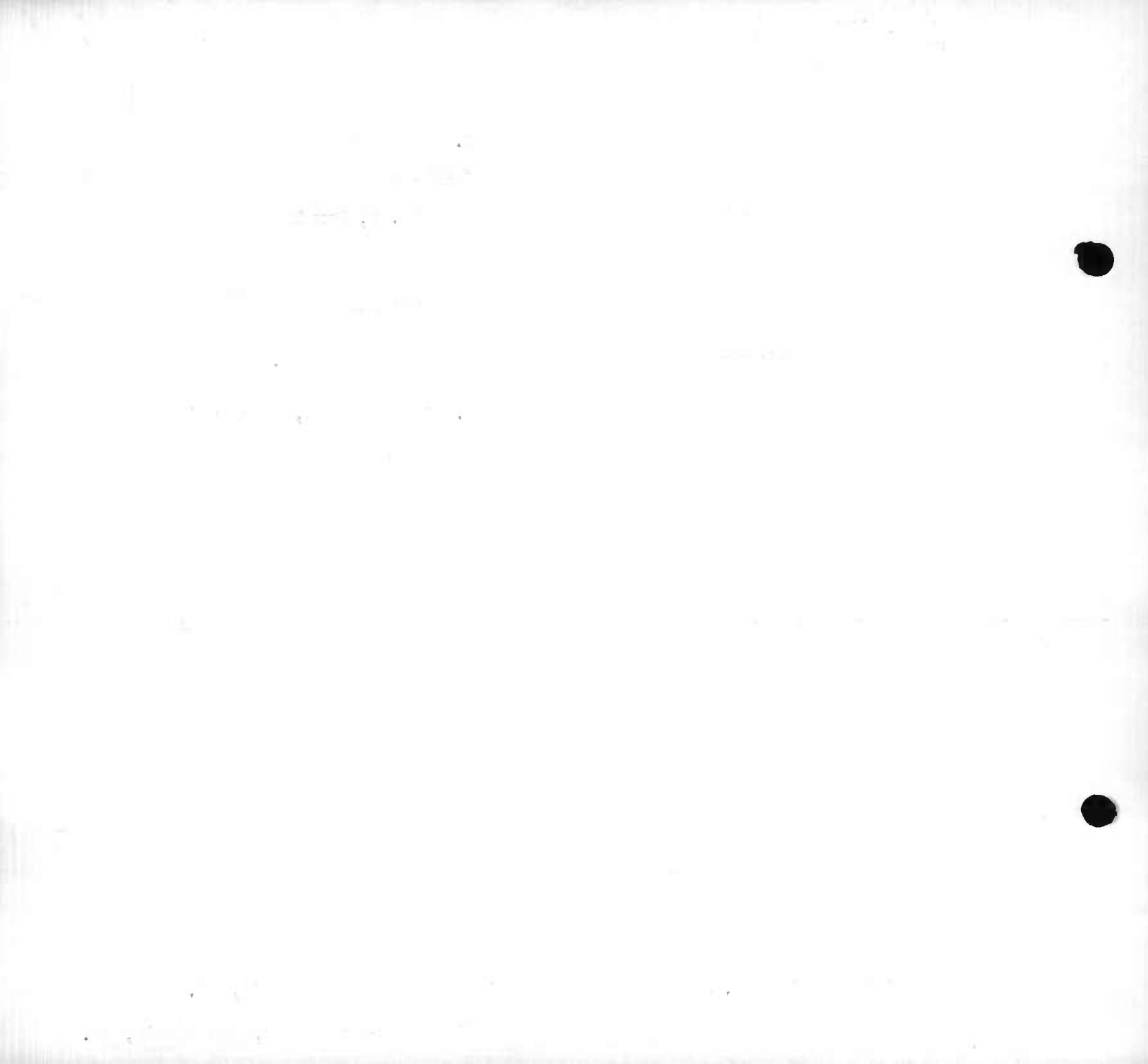
4-21-70

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3961</u>	
BIRTH NO. <u>8-550</u>		70 3961		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>PATRICIA BOWMAN</u>		2. DATE AND HOUR OF DEATH <u>4-13-70</u> <u>10⁰⁰</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mercy Hospital</u>		A. STATE <u>Md.</u>		B. COUNTY <u>AA</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Pasadena</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>Rte. 9, Box 280 A</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-2-66</u>	9. AGE (In years last birthday) <u>3</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Linda K. Bowman</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Sidney Hynson, same as 4</u>	
18. <u>204.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>probable CNS involvement + day</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute Lymphocyte Leukemia</u> <u>2 yrs</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>none</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10:50 pm April 13</u> 19 <u>70</u> to <u>10:50 pm April 13</u> 19 <u>70</u> and that (I) (we) last saw the deceased alive on <u>10:50 pm April 13</u> 19 <u>70</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Bar F. Chen</u>		23B. DATE SIGNED <u>13/4/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Bar F. Chen</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>16 Apr. 70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u>	
24D. LOCATION <u>Glen Burnie, Md.</u>		24E. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		24F. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

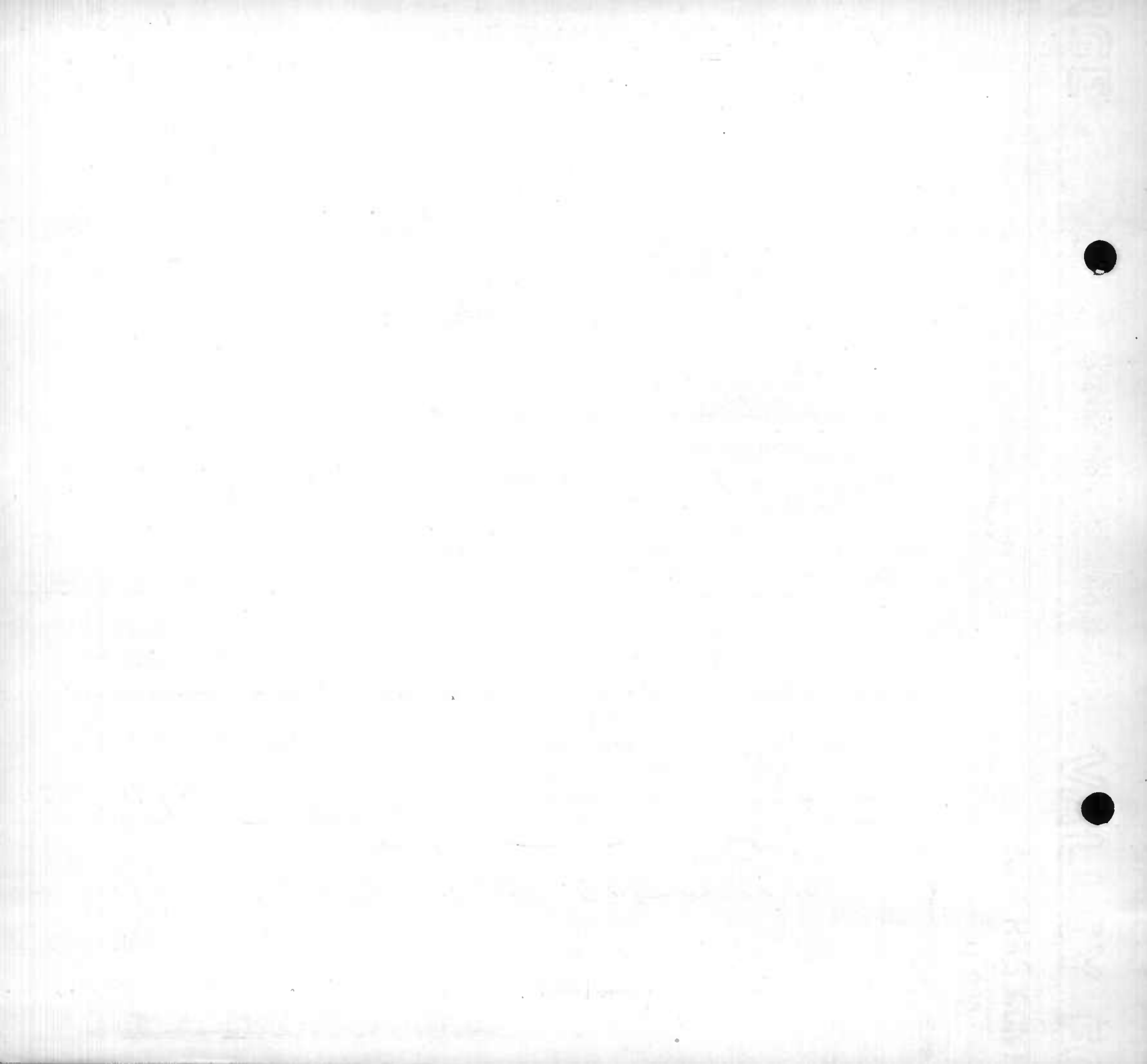
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		IRWIN, Meredith B		2. DATE AND HOUR OF DEATH		12 APRIL 1970 12:10 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		HARFORD C	
23 VETERANS ADMINISTRATION HOSPITAL		3900 LOCH RAVEN BOULEVARD		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
BALTIMORE, MARYLAND 21218		ROUTE 2 BOX 99		STREET		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		CAUCASION		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4-6-20	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
PAINTER				50		CLOUDS, TENNESSEE	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		U. S. A.	
NATHANIEL GREEN IRWIN		MARY CATHERINE DANIELS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
YES		10-10-40 TO 5-28-45		410-14-42-37		17. INFORMANT	
						VA HOSPITAL RECORDS	
						ADDRESS	
						3900 LOCH RAVEN BLVD, BALTO, MD 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Chronic Renal Failure		months	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:					
II		Hepatoma Suspect					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
						No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (u) (this hospital) attended the deceased from 30 MARCH 1970 to 12 APRIL 1970		that (u) (we) last saw the deceased alive on 12 APRIL 1970		and that in (u) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
YOUNG E. CHUN, M.D.		April 13, 1970		YOUNG E. CHUN, M.D.		3900 LOCH RAVEN BOULEVARD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-16-70		Drummond's		New Tazewell, Tennessee	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 15 1970		Robert E. Taylor, M.D.		John H. Harkins, Delta, Penna.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3963	
B-660 18-07745 70 3963 BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BABY GIRL BREWER			2. DATE AND HOUR OF DEATH 4/11/70 8⁴⁵ P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1914 E. BALTIMORE STREET 6-04		
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-70	9. AGE (In years lost birthday) 3	If Under 1 Yr. Months - Days 3 If Under 24 Hrs. Hours - Min. -
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JODY BREWER			
14. MOTHER'S MAIDEN NAME AVIS LOWERY				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 740X I CAUSE OF DEATH cardiorespiratory arrest 5 min. anencephalus ~ 3 days			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			19A. DATE OF OPERATION		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4/8/1970 to 4/11/1970, that (I) last saw the deceased alive on 4/11/1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE James W. Hanson MD				23B. DATE SIGNED 4/11/70	
23C. PHYSICIAN'S NAME (Type) JAMES W..HANSON		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4/13/70		24C. NAME OF CEMETERY or CREMATORY Johns Hopkins Hospital	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25A. DATE REC'D BY HEALTH DEPT. APR 15 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL			



BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3964	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Alberta Stevenson			2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 514 E. 20th St.			3. DATE PRONOUNCED DEAD Month Day Year Hour 4 13 70 3:05 p M.		
6. SEX female			5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 908		
7. RACE colored		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 3/14/89		10. AGE (in years last birthday) 71		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF U.S.A.		E. STREET AND NUMBER 514 E. 20th St.	
14A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME John Woodward	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME Hannah Patterson	
18. INFORMANT Bessie Mae Brocuy		ADDRESS 220 E 25th St.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION 4/12/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) no
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/13/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/17/70		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park	
24D. LOCATION (City, town, or county) (State) Arbutus, Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Gaunt Elicitor	
				ADDRESS 1129 N. Caroline St.	

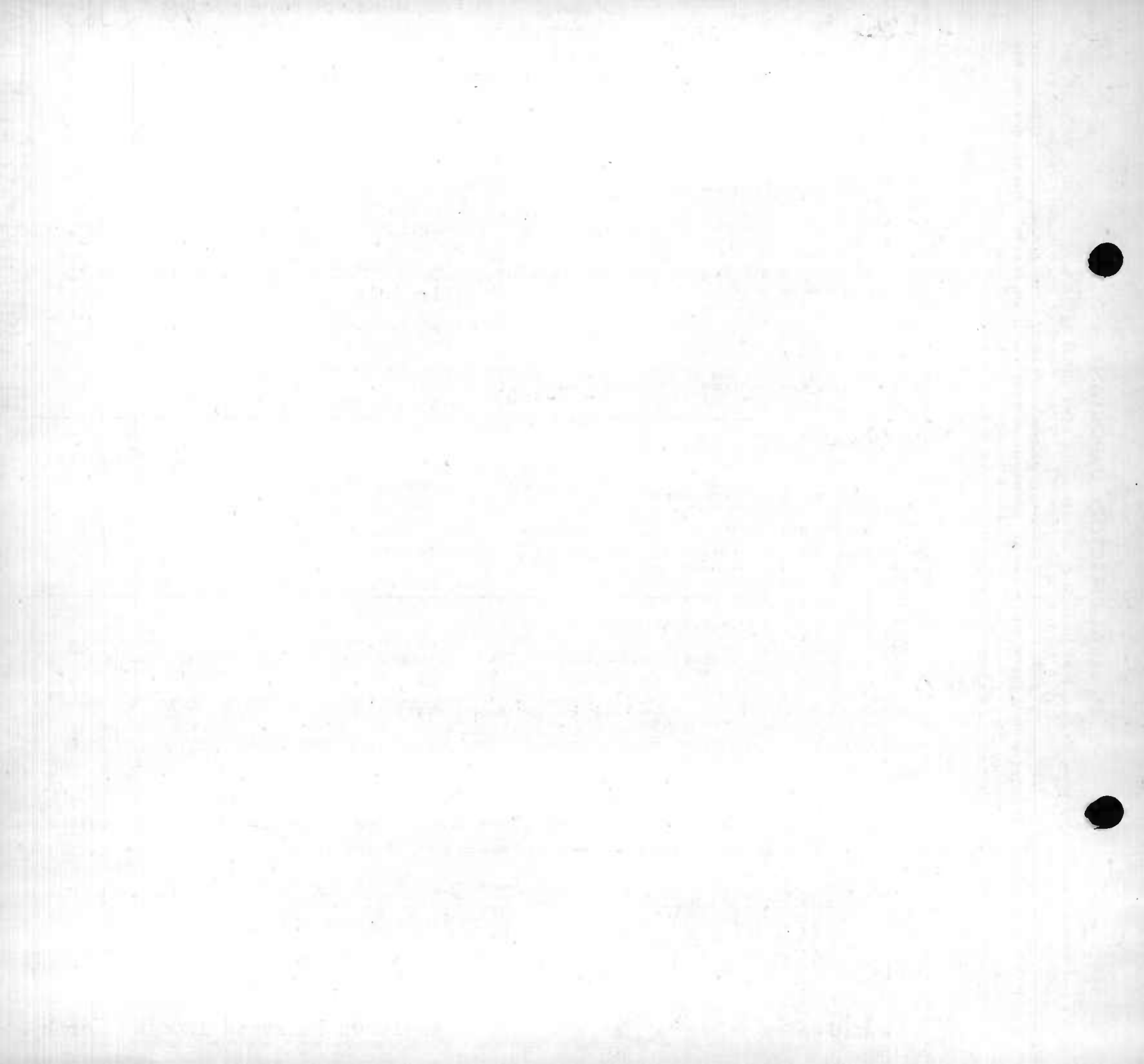
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

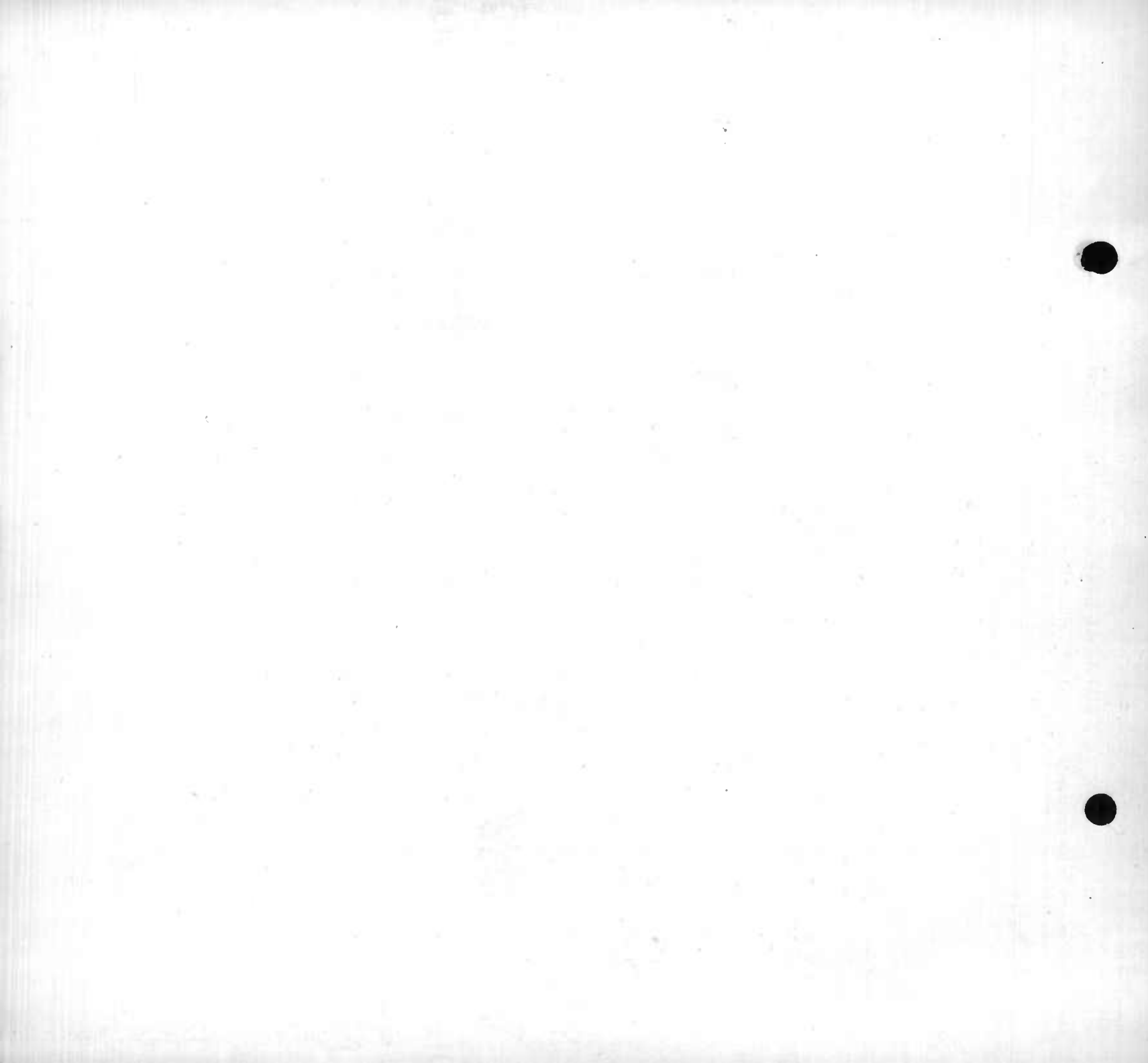
Baltimore City Health Department				REG. NO. 70 3965	
BIRTH NO. 4-625 70 3965		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) George Harrison (HAIRSTON)		2. DATE AND HOUR OF DEATH 4/11/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital 38		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE 602 Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 102 N Poppleton St			
5. SEX M	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1919	9. AGE (In years lost birthday) 50	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME ?			
14. MOTHER'S MAIDEN NAME ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 231-07-4493		17. INFORMANT Mrs Alice Williams, Same			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 74 RS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-15-63 to 4-11-1970, that (I) (we) last saw the deceased alive on 3-30-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Maurice L. Adams M.D.				23B. DATE SIGNED 4-13-70	
23C. PHYSICIAN'S NAME (Type) MAURICE L. Adams M.D.				23D. ADDRESS 238 N Carey St	
24A. BURIAL CREMATION Burial		24B. DATE 4/16/70		24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. APR 15 1970			
25B. NAME OF REGISTRAR Robert E. Halstead		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North A			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3966	
D-263 70 3966		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Daugherty Robert</i>		2. DATE AND HOUR OF DEATH <i>4-14-70 3:50 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hosp. of Md.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <i>1607</i> YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1501 N. Dukeland st. (Dukeland nursing home)</i>			
5. SEX <i>M</i>	6. RACE <i>negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/24/89</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i>		16. SOCIAL SECURITY NO. <i>216-18-7057</i>		17. INFORMANT <i>Mr James H Daughtey, 3013 Mondamin Ave</i>	
18. <i>4369+1 0949</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>cerebrovascular Accident</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Accident</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET OF DEATH <i>18 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Neurosyphilis</i>					
19A. DATE OF OPERATION <i>No operation</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>No operation</i>		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>No injury</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <i>No injury</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-27-70</i> 19 <i>70</i> to <i>4-14</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>4-14</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Behnaz Jalali</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4-14-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Behnaz Jalali</i>		23D. ADDRESS <i>Lutheran Hosp. of Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/17/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>National Cemetery</i>	
24D. LOCATION <i>Baltimore Md</i>		24E. FUNERAL DIRECTOR <i>Adolphus Halstead</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1970</i>		25B. NAME OF REGISTRAR <i>John E. Fisher, Md.</i>		25C. ADDRESS <i>1206 W North Av</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3967

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

REXRAW MAYS (Mace)

2. DATE
OF
DEATHKnown ☐
Estimated ☐Month
4 10Day
70Year
6:15 aHour
M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital D.O.A.

3. DATE
PRONOUNCED DEADMonth
AprilDay
10,Year
1970Hour
6:15 a

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

808

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

10. AGE (in years
last birthday)
47If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1033 N. Chapel St.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
U WHAT COUNTRY?

13. FATHER'S NAME

Joe Rakestraw

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ethel Foster

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Oveta Marsh, Charlotte N, C

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Fatty liver

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/17/70

24C. NAME OF CEMETERY or CREMATORY

MT Auburn Cemetry

24D. LOCATION

(City, town, or county)

Baltimore M

(State)

25A. DATE REC'D BY HEALTH DEPT

APR 15 1970

25B. NAME OF REGISTRAR

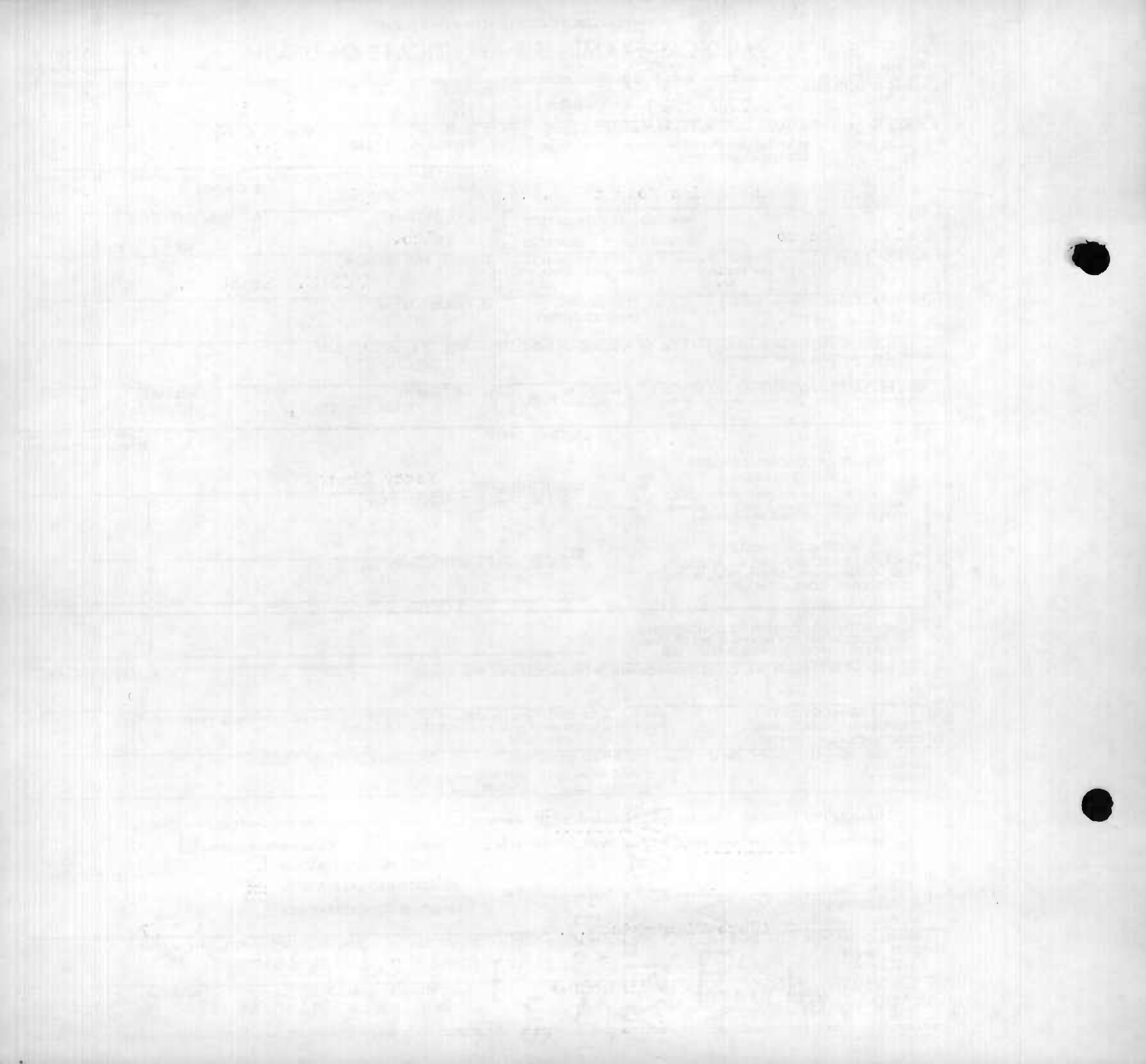
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W

ADDRESS

North A



1

T-425 70 3968

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3968

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD TILGHMAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 13 1970 9:12 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 1877		10. AGE (In years lost birthday) 93	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Soloman J. Tilghman		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1608	
15. MOTHER'S MAIDEN NAME Mary J. Other		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Mahalia A. Green 607 Edgewood St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive & Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. DATE SIGNED 4-13-70 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-70	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

VS 151-REV. 1/1/68

ACADEMY BOARD

J-162 70 3969

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3969

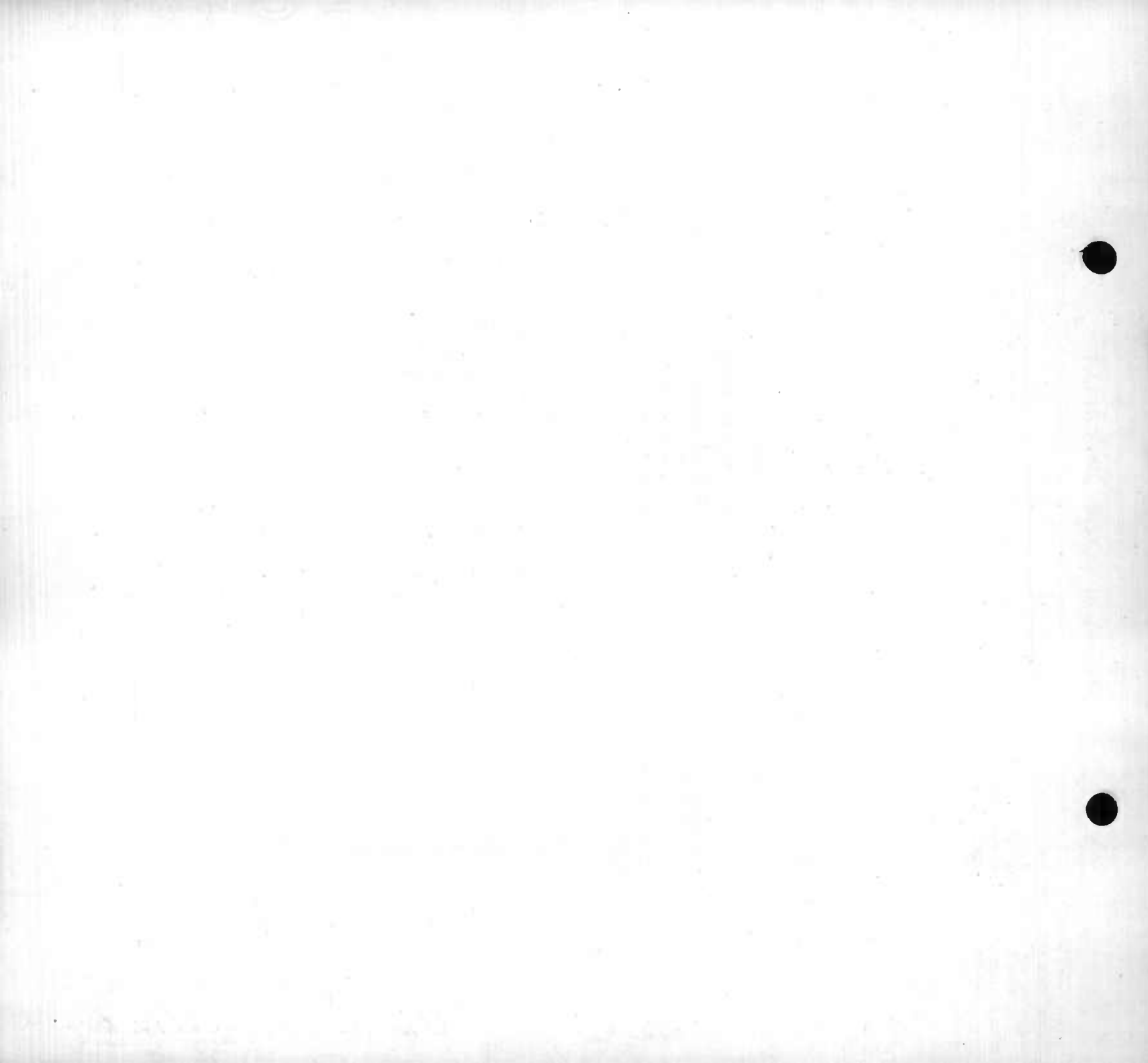
BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALFRED C. JEFFERSON JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1011 W. Lexington St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 13 1970 9:35 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 501			
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 9-17-14	10. AGE (In years last birthday) 55	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 1011 W. Lexington St.
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Alfred C. Jefferson	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Grace Pace	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.	
18. INFORMANT Grace Jefferson		ADDRESS 602 Joseph Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive & Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Detroit, Mich. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 4-13-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-20-70	
24C. NAME OF CEMETERY or CREMATORY Detroit		24D. LOCATION (City, town, or county) (State) Detroit, Mich.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3970	
BIRTH NO. 525		70 3970		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JOHNSON, Clara Ellistine			2. DATE AND HOUR OF DEATH April 12, 1970 6:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Convalescent & Nursing Ctr.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2002		
5. SEX F 6. RACE N 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			E. STREET AND NUMBER 2811 Kinsey Avenue		9. AGE (In years last birthday) 97
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charlie Powell			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-54-8270		17. INFORMANT Kenneth Johnson 2811 Kinsey Ave.	
18. 436.9 & 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). DIABETES			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) CELEBRARY VEHICLE ACCIDENT (C) GENERALIZED ARTERIO SCLEROSIS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edmundo Larranaga M.D.				23B. DATE SIGNED 4-12-70	
23C. PHYSICIAN'S NAME (Type) EDMUNDO LARRANAGA M.D.				23D. ADDRESS 900 WOODSON RD - F BALTO, MD 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/70		24C. NAME OF CEMETERY OR CREMATORY Winstanburn	
24D. LOCATION Baltimore, Md.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR Charles A. Kuebbel W. Barry	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>I-610</u> <u>70</u> <u>3971</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70</u> <u>3971</u>	
1. NAME OF DECEASED (Type or Print) <u>Michelle Irby</u>				2. DATE AND HOUR OF DEATH <u>April 13</u> <u>4:30 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD.</u>		B. COUNTY <u>16-05</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2515 Edmondson Ave</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/51</u>	9. AGE (In years last birthday) <u>18</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Joseph Brown</u>				14. MOTHER'S MAIDEN NAME <u>Michelle Irby, Mary</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARY Hattie Roulette</u> <u>2604 Oakley Ave.</u> <u>Mathea</u> <u>same</u>		
18. <u>395.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertrophic Subaortic Stenosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>6</u> to <u>April</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>April 13</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Gary M. Latta</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/13/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>GARY M. Latta</u>				23D. ADDRESS <u>Univ. Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/17/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u>		ADDRESS <u>661 W. Barnes St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3972	
BIRTH NO. 70 3972		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Kelly, James A. (Kelley)		2. DATE AND HOUR OF DEATH 4/13/70 1 3⁰⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD St. Bon Secours Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2001	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Bon Secours Hospital		C. CITY OR TOWN Baltimore	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 1838 W. Saratoga Street	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 46 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Maryland, Balto.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James R. Kelly		14. MOTHER'S MAIDEN NAME Anna Ames	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/27/43 1/21/46		16. SOCIAL SECURITY NO. 214-16-9151	17. INFORMANT Chart (Mrs. Gladys Kelly)
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Adrenal insufficiency ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Tuberculosis in both adrenals?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/25 19 70 to 4/13 19 70 that (I) (we) last saw the deceased alive on 4/13 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Mayuree Khongcharoensuk, M.D.		23B. DATE SIGNED 4/13/70	
23C. PHYSICIAN'S NAME (Type) MAYUREE KHONGCHAROENSUK M.D.		23D. ADDRESS Bon Secours Hosp. Balto. Md. 21203	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/17/70	24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l Cem.	24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taber, M.D.	
25C. FUNERAL DIRECTOR Morton Dyett F.H.		ADDRESS 1701 Laurens St.	

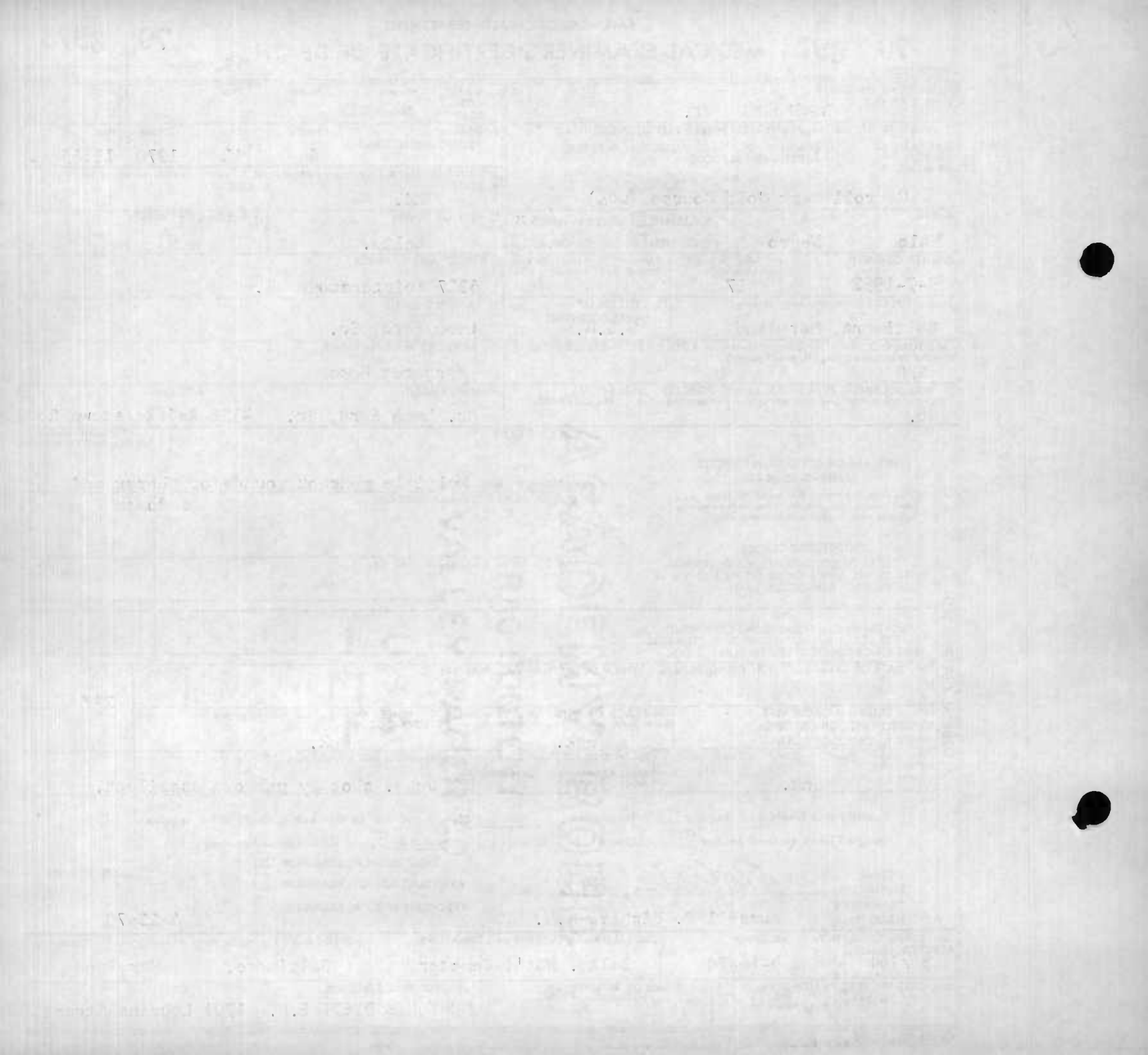
70 3973 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3973

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) LEON FORD, Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Carroll Park Golf Course (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 12 1970 11:45 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 5-7-1952		10. AGE (In years lost birthday) 17	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. Leon Ford, Sr.		ADDRESS 4322 Reisterstown Road	
19. CAUSE OF DEATH E965 X1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple gunshot wounds of thorax and abdomen DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unk.	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Unk.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Unk.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subj. shot by unknown assailant.	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-13-70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-70	
24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Russell S. Fisher, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-4351

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3974	
70 3974				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Borden, Emma H.</u>		2. DATE AND HOUR OF DEATH <u>9 April 1970 11:15 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2037</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u> <u>Granada Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>3/12/76</u>		9. AGE (In years last birthday) <u>94</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Rock B: S H, VA.</u>	
13. FATHER'S NAME <u>Phil Johnson</u>		14. MOTHER'S MAIDEN NAME <u>EMMA Bridgewater</u>		12. CITIZEN OF WHAT COUNTRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Mable Smith</u>	
18. <u>410.941 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>years</u> <u>years</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>4 March</u> 19 <u>70</u> to <u>9 April</u> 19 <u>70</u> , that (1) (we) last saw the deceased alive on <u>9 April</u> 19 <u>70</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert C. Blackman, M.D.</u>				23B. DATE SIGNED <u>9 April 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert C. Blackman, M.D.</u>				23D. ADDRESS <u>Granada Nursing Home</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/15/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Bapt. Ch. Cem.</u>	
24D. LOCATION (City, town, or county) <u>Nelson Co.</u>		24E. LOCATION (State) <u>Virginia</u>		24F. LOCATION (City, town, or county) <u>1701 Laurens St.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Horton's Dyett F.H.</u>	

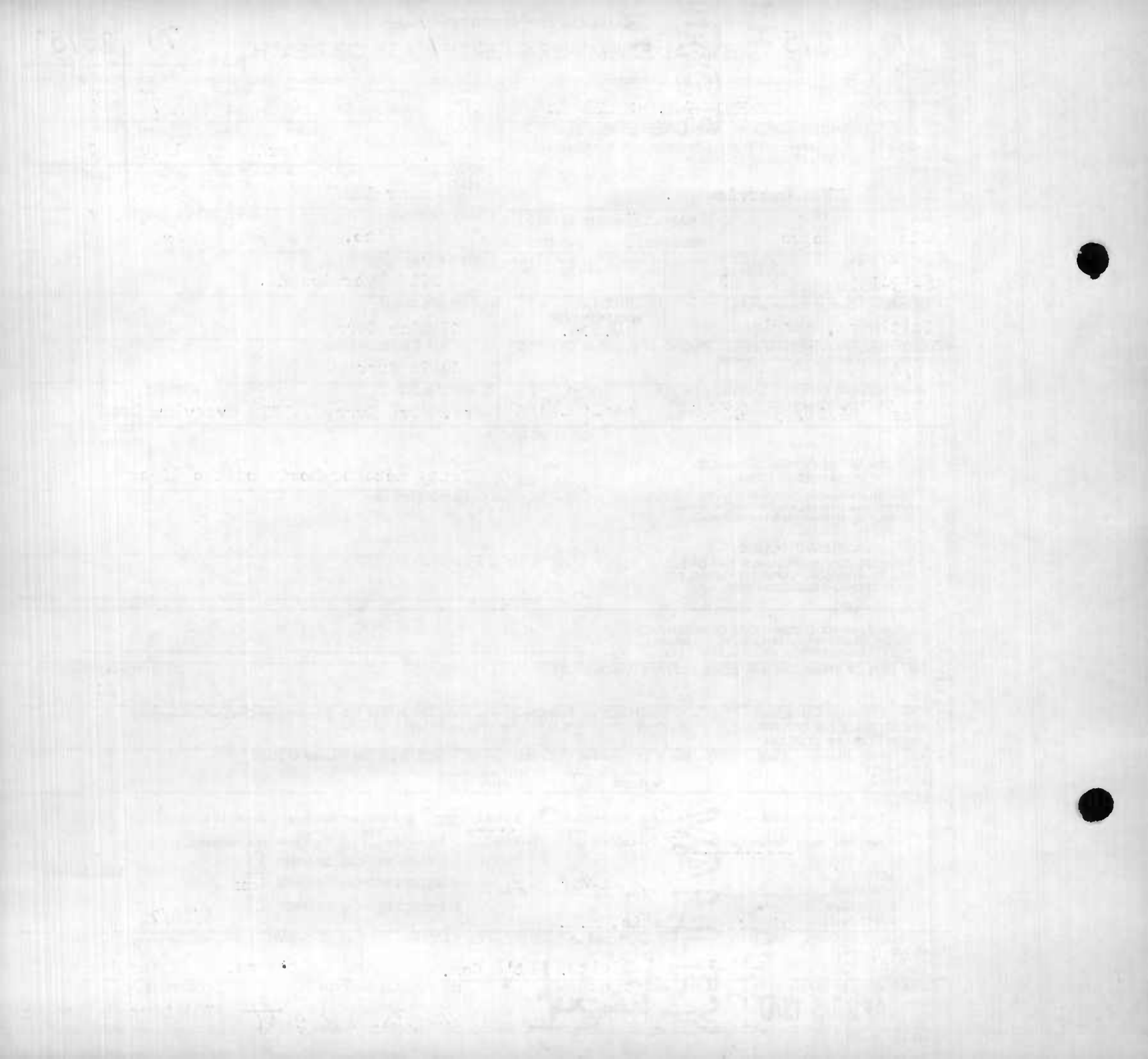


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) IRVING HICKS CURRY SR.		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 9 Year 70 Hour 7 p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3728 Overview Rd.		3. DATE PRONOUNCED DEAD Month April Day 9, Year 1970 Hour 7 p M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 8-19-1926		10. AGE (In years lost birthday) 43	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kiahlee Curry		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1512	
15. MOTHER'S MAIDEN NAME Julia Curry		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes 2/28/45 4/26/46	
17. SOCIAL SECURITY NO. 212-20-0106		18. INFORMANT Mrs. Mary Curry	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of the liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 22		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/10/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-13-70	
24C. NAME OF CEMETERY OR CREMATORY Balto. Nat'l Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR ADDRESS Mortimer G. Dyett 1701 Laurens Street			



1
J-520

70 3976

BALTIMORE CITY HEALTH DEPARTMENT

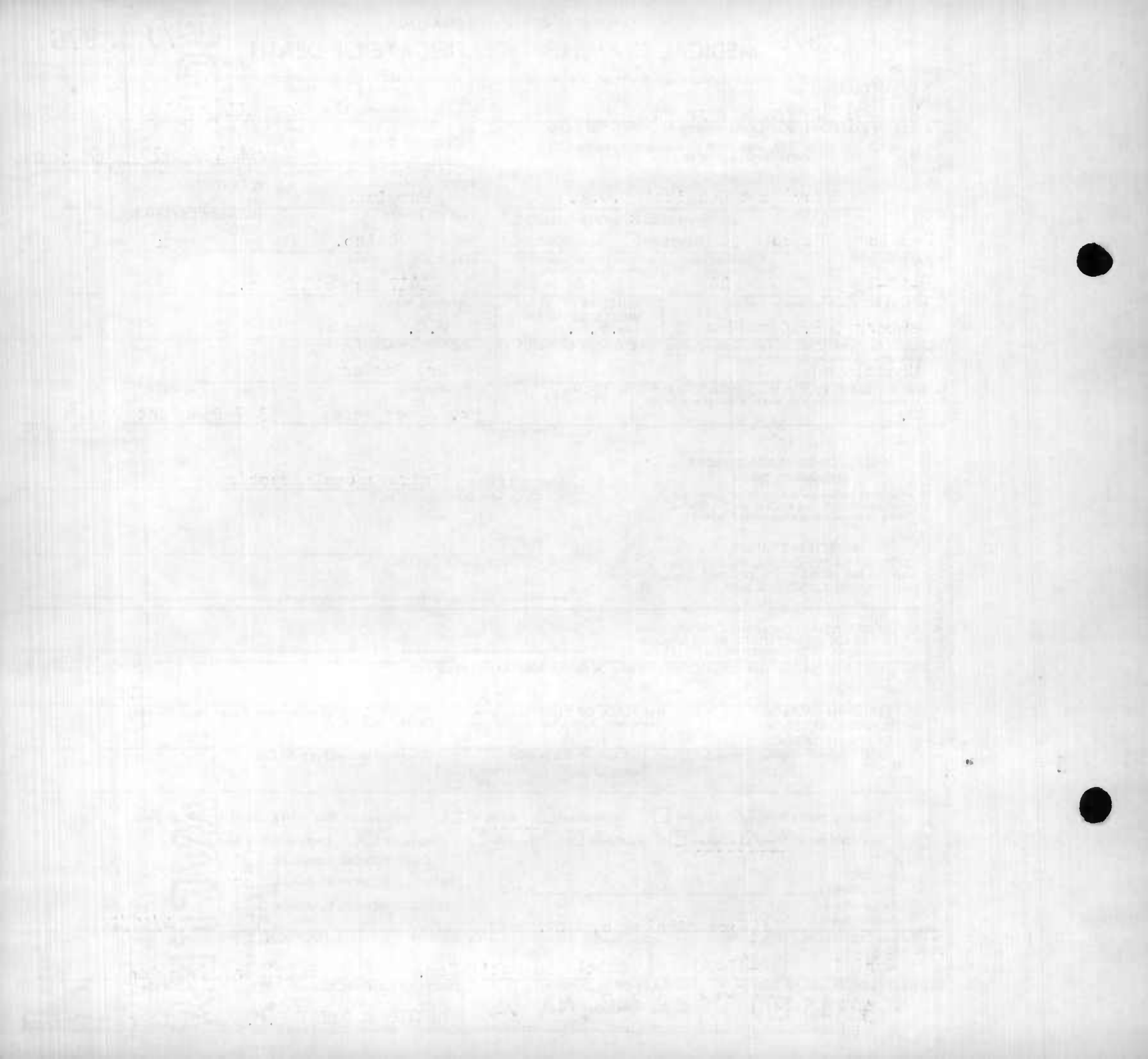
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3976

REG. NO.

BIRTH NO.

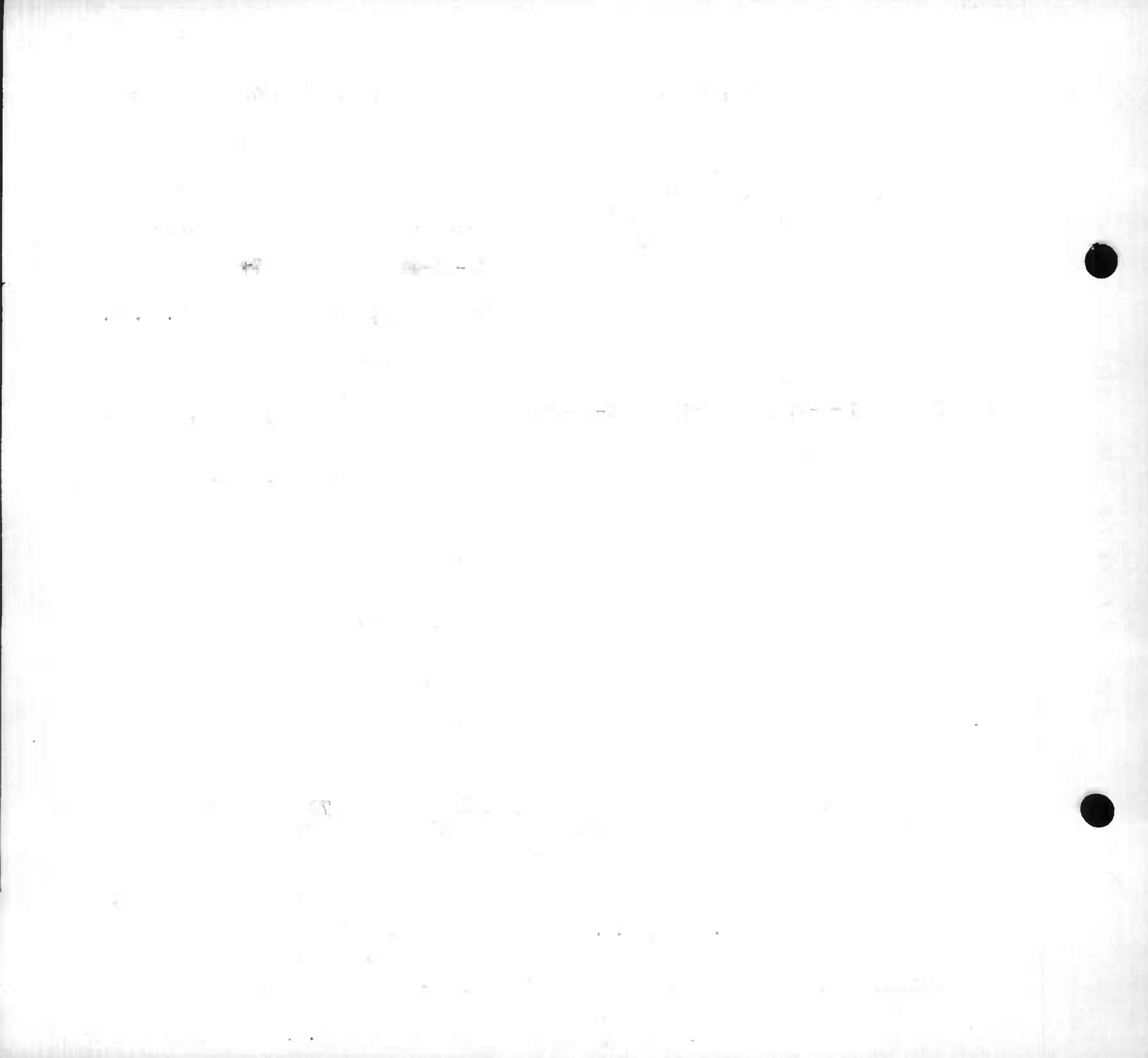
1. NAME OF DECEASED (Type or Print) (Willie) WILLA MAE JONES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 4 11 70 7:00 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour April 11, 1970 7:00 p.m.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 8-22-1945		10. AGE (In years last birthday) 24 If Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Newberry, S. Carolina		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO.	
18. INFORMANT Mr. James Jones		ADDRESS 5307 Beaufort Avenue	
19. 304.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intravenous narcotism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE (B) (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-70	
24C. NAME OF CEMETERY or CREMATORY Baltimore Nat'l Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taber, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

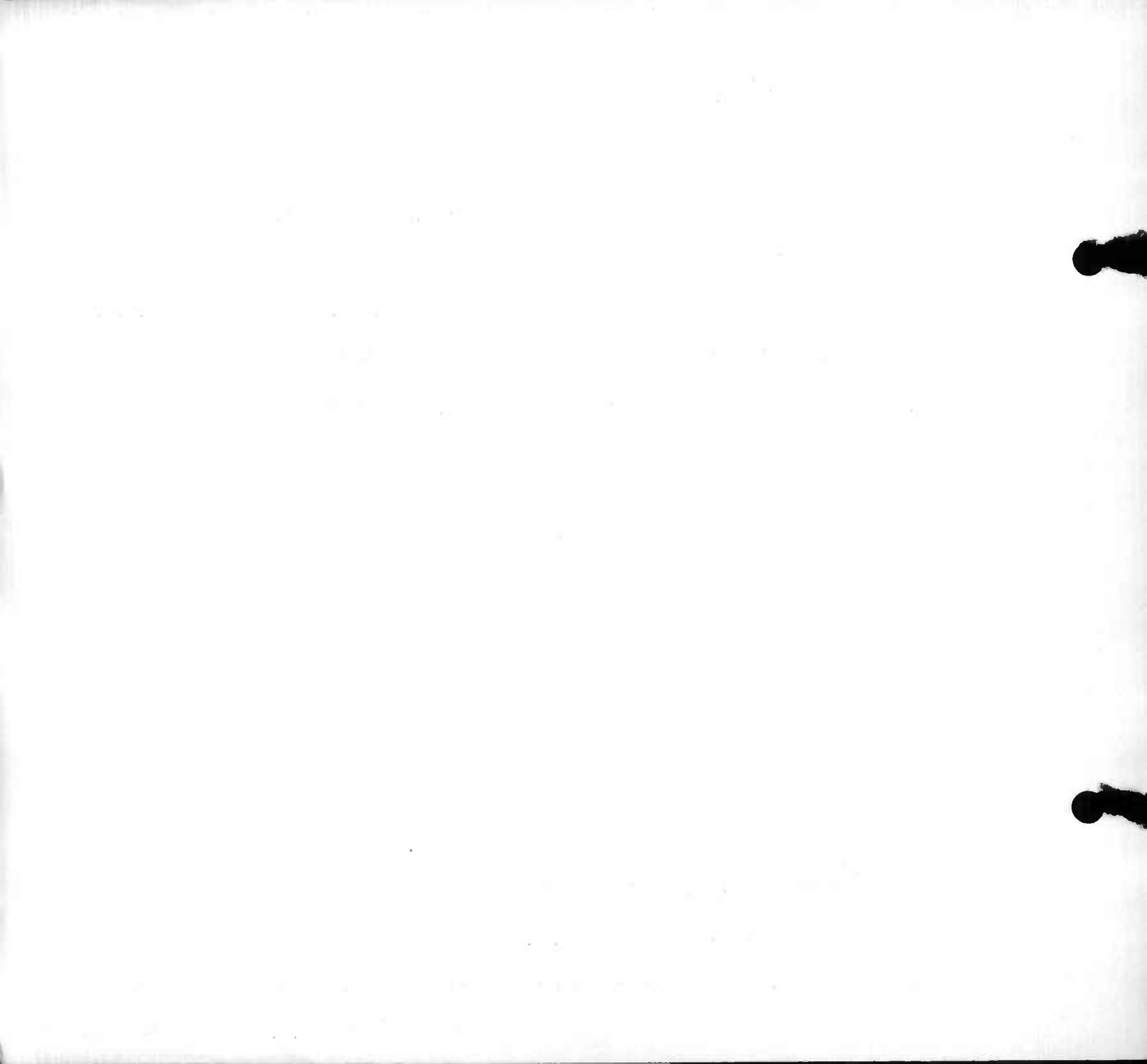
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3977	
70 3977				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIAMS, Eprain NMI (Ephriam)		12 APRIL 1970 4:00 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
23 VETERANS ADMINISTRATION HOSPITAL				MARYLAND BALTIMORE CITY 1503	
3900 LOCH RAVEN BOULEVARD				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
BALTIMORE, MARYLAND 21218				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER	
MALE		NEGROID		1723 MORELAND AVENUE 21216	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9. AGE (in years last birthday) 12-31-99 70	
PORTER				11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?	
				KEYESVILLE, VIRGINIA U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
SAM WILLIAMS				FANNIE WATSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES 12-7-17 TO 12-7-19		217-52-6028		VA HOSPITAL RECORDS 3900 LOCH RAVEN BLVD, BALTO, MD 21218	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				WEEKS	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				Cerebrovascular accident	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Diabetes mellitus	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (u) (this hospital) attended the deceased from 9 APRIL 1970 to 12 APRIL 1970 that (u) (we) last saw the deceased alive on 12 APRIL 1970 and that in (u) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
YOUNG E. CHUN, M.D.				April 13, 1970	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. DATE SIGNED	
		3900 LOCH RAVEN BLVD BALTO, MD 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
XXXXXXX Burial		4-15-70		Baltimore Nat'l Cem.	
25A. DATE OF BURIAL		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 15 1970		MORTON & DYETT F.H.		1701 Laurens Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3978	
BIRTH NO. 70 3978		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) REV. WILLIAM WHITT			2. DATE AND HOUR OF DEATH April 12, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 MT SINAI NURSING HOME			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 273 S. Dallas Court		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1903	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oconie Co., S. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Ceasar Whitt		
14. MOTHER'S MAIDEN NAME Fannie Whitt			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		
16. SOCIAL SECURITY NO. 251-09-4050			17. INFORMANT Mrs. Sadie Whitt		
18. ADDRESS 273 Dallas Court			19. CAUSE OF DEATH		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Pneumo pneumonia DUE TO, OR AS A CONSEQUENCE OF: Cerebro Vase Accident (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C)		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1 yr			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 1969 19 to April 12 19 70 that (I) (we) last saw the deceased alive on April 12 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward S. Kallins, M.D.			23B. DATE SIGNED 4/14/70		
23C. PHYSICIAN'S NAME (Type) Edward S. Kallins, M.D.			23D. ADDRESS MORTON & DYETT F.H. 1701 Laurens Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-16-70		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 15 1970			
25B. NAME of REGISTRAR E. J. Taylor, Jr.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens Street			



FUNERAL DIRECTOR: IMPORTANT

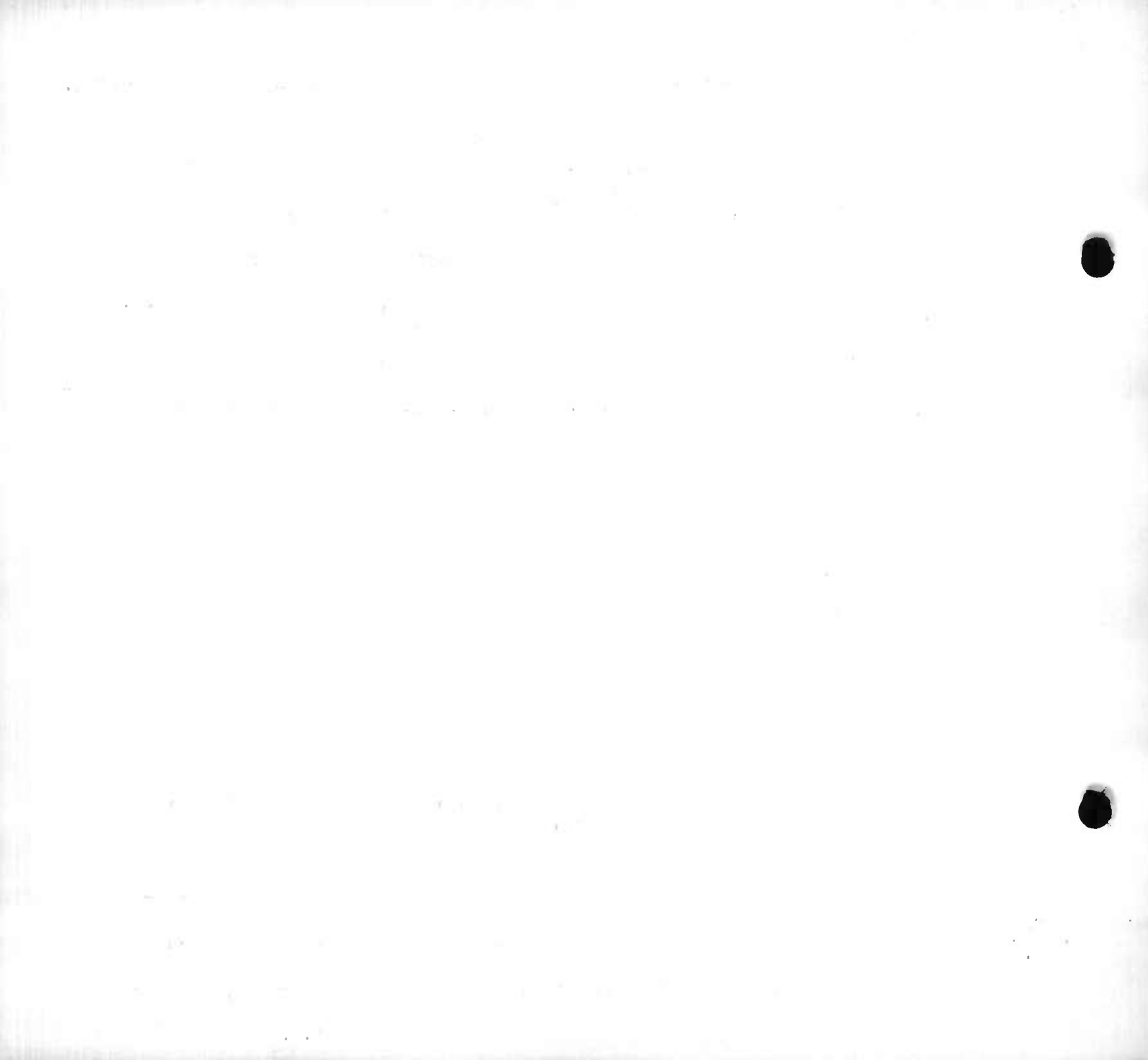
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 3979	
BIRTH NO.		70 3979	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
JESSIE WOOTEN (Wooten)		4/10/70 9:32 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION M.D. GEN. HOSPITAL		A. STATE BALTO.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY BALTO.	
5. SEX F		6. RACE N	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/26/21	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSER		9. AGE (in years lost birthday) 48 yrs	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) P.H. Co, North Carolina	
13. FATHER'S NAME LOVE BLOW.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME MARINA BARRETT		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.	
16. SOCIAL SECURITY NO. 237-30-2494		17. INFORMANT Mr. Sam Wooten	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral Edema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48-72 h.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aneurysm of post. cereb. artery with rupture	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: Post-clipping Cerebral	
19A. DATE OF OPERATION 3/4/8/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intra-cranial Aneurysm	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., at home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/2/1970 to 4/10/70 that (I) (we) last saw the deceased alive on 4/10/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE M. Ranganathan		23B. DATE SIGNED 4/10/70	
23C. PHYSICIAN'S NAME (Type) H.S. RANGANATH		23D. ADDRESS M.D. Gen Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/14/70	
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Bapt. Ch. Cem.		24D. LOCATION Greenville, N.C.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR R. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Mortimer & Dyett		ADDRESS 1701 Laurens St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3980</u>	
BIRTH NO. <u>70 3980</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lillian Clark</u>			2. DATE AND HOUR OF DEATH <u>4-12-70</u> <u>5:30 a.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>Provident Hospital, Inc.</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1403</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2024 Division Street</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-07</u>	9. AGE (In years last birthday) <u>63</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unk.</u>			14. MOTHER'S MAIDEN NAME <u>Unk.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>218-22-5231</u>		17. INFORMANT <u>Mrs. Lillian Walker-Godchild</u> ADDRESS <u>4925 Lemere Ave</u>
18. <u>427.01</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Congestive Heart Failure</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 30,</u> <u>1970</u> to <u>April 12,</u> <u>1970</u> that (I) (we) last saw the deceased alive on <u>April 12,</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Raymundo R. Corpuz, M.D.</u>			23B. DATE SIGNED <u>4-13-70</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>Raymundo R. Corpuz, M.D.</u>			23D. ADDRESS <u>1514 Division Street Balto., Maryland</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4-16-70</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Western Star Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Catonsville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTON & DYETT F.H.</u> ADDRESS <u>1701 Laurens Street</u>	



E-152

70 3981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 3981

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Walter C. Evans		4/13/1970 2.28 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE & COUNTY Maryland	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2301 Koko Lane 21216	
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-20-26	9. AGE (In years last birthday) 43
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Walter Evans		14. MOTHER'S MAIDEN NAME Vashti Evans			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 2/3/45 8/3/46		16. SOCIAL SECURITY NO. 243-30-2662		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Pseudomonas (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia 10 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chemotherapy (B) DUE TO, OR AS A CONSEQUENCE OF: Acute Myelocytic Leukemia 35 days 9 mos.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from JANUARY 19 70 to 13 April 1970 that (we) last saw the deceased alive on 13 April 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel C. Hadlock MD				23B. DATE SIGNED 13 April 1970	
23C. PHYSICIAN'S NAME (Type) DANIEL C. HADLOCK MD				23D. ADDRESS Baltimore City Hospitals, 4940 Eastern 303 Oakdale Road, Balt. Md. 21210	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-70		24C. NAME OF CEMETERY or CREMATORY Balto. Nat'l Cem.	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens Street	

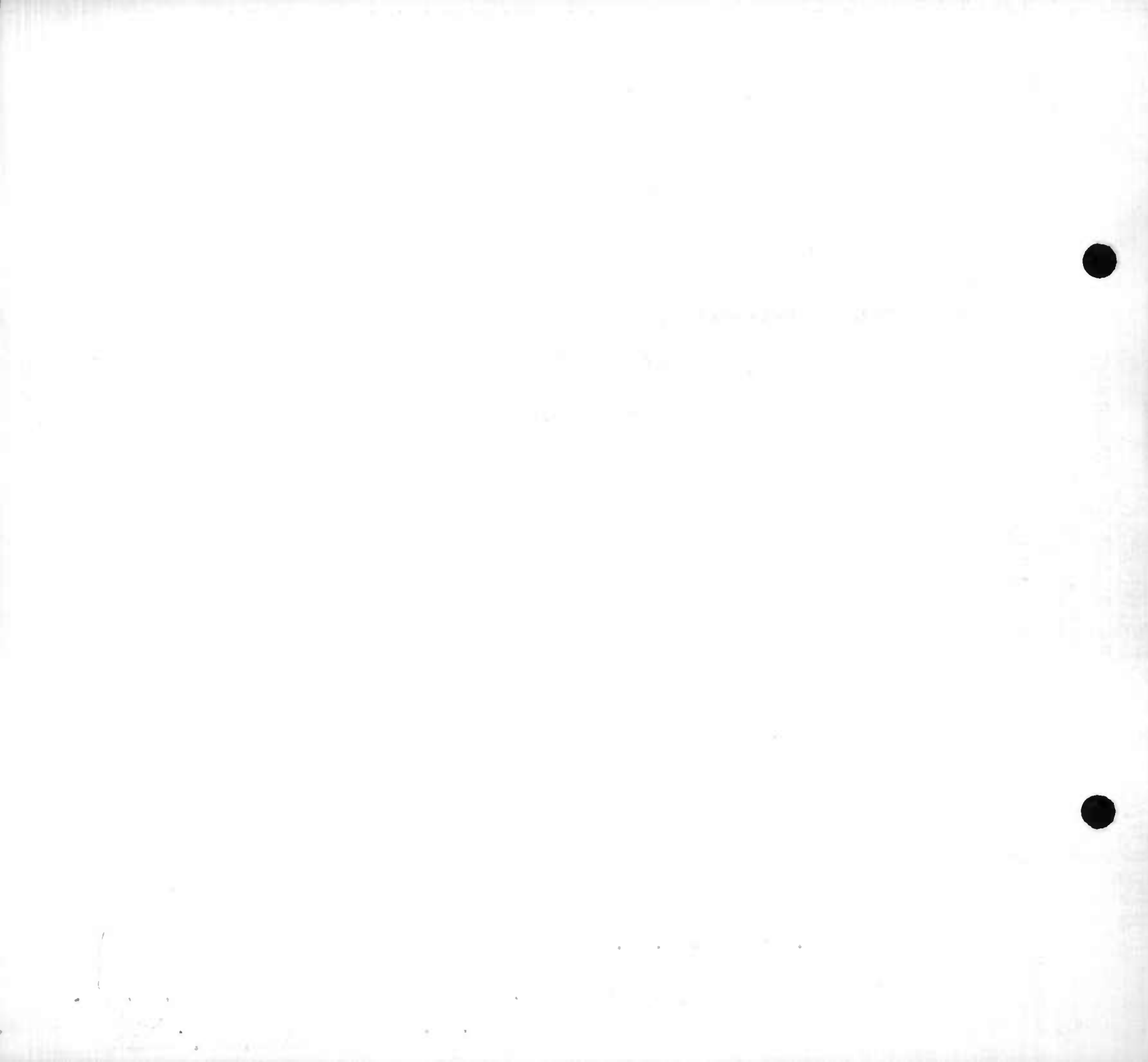
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-356 70 3982				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3982	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>William Buddemeyer</i>		2. DATE AND HOUR OF DEATH <i>13 April 1970 1935 P M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Union Memorial Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>902</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Union Memorial Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1529 Medford Road</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>06-12-02</i>	9. AGE (in years last birthday) <i>67</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED - CIVIL ENGINEER</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>BALTO. CITY</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Buddemeyer, William F.</i>			
14. MOTHER'S MAIDEN NAME <i>Dorothy Shipley</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>314-18-1812</i>				17. INFORMANT <i>MRS. MARGARET Z. BUDDEMEYER</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Multiple Pulmonary Embolism</i>				19. CAUSE OF DEATH <i>Multiple Pulmonary Embolism</i>			
19A. DATE OF OPERATION <i>4-30-70</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinomatosis</i>			
20A. AUTOPSY? (Yes or No) <i>Yes</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>3-31-70</i> to <i>4-13-70</i> that (2) (we) last saw the deceased alive on <i>4-13-70</i> and that (3) (my) opinion death occurred on the date and hour and from the causes stated above, (4) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>M. Cepeda M.D.</i>				23B. DATE SIGNED <i>13 April 70</i>			
23C. PHYSICIAN'S NAME (Type) <i>M. Cepeda, M. D.</i>				23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>4/17/70</i>			
24C. NAME OF CEMETERY or CREMATORY <i>Moreland Mem. Park</i>				24D. LOCATION (City, town, or county) (State) <i>Parkville, Balto. Co. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1970</i>				25B. NAME OF REGISTRAR <i>Robert E. Jaber, M.D.</i>			
25C. FUNERAL DIRECTOR <i>H. W. Jenkins & Sons Co.</i>				25D. ADDRESS <i>4905 York Rd. Balto., Md. 21212</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 3983	
BIRTH NO. 3-650 70 3983		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) LOUIS GUARINO		2. DATE AND HOUR OF DEATH APRIL, 14th 1970		6:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		302	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md. B. COUNTY BALTO.		C. CITY OR TOWN BALTO.	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 404 S. EXETER ST.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/4/84	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY BALTO. TRANSIT.		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? ITALY		13. FATHER'S NAME ANTONIO GUARINO		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-05-9422		17. INFORMANT MR. ANTHONY GUARINO 404 S. EXETER ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular thrombosis			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 14, 1970 to April 14, 1970, that (I) (we) last saw the deceased alive on April 14/70, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) DR. MILITO M. TORRES		23D. ADDRESS 441 S. ELIWOOD ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/17/70		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER	
24D. LOCATION BALTO. Md.		24E. NAME OF CEMETERY or CREMATORY		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS 322 S. HIGH ST.	

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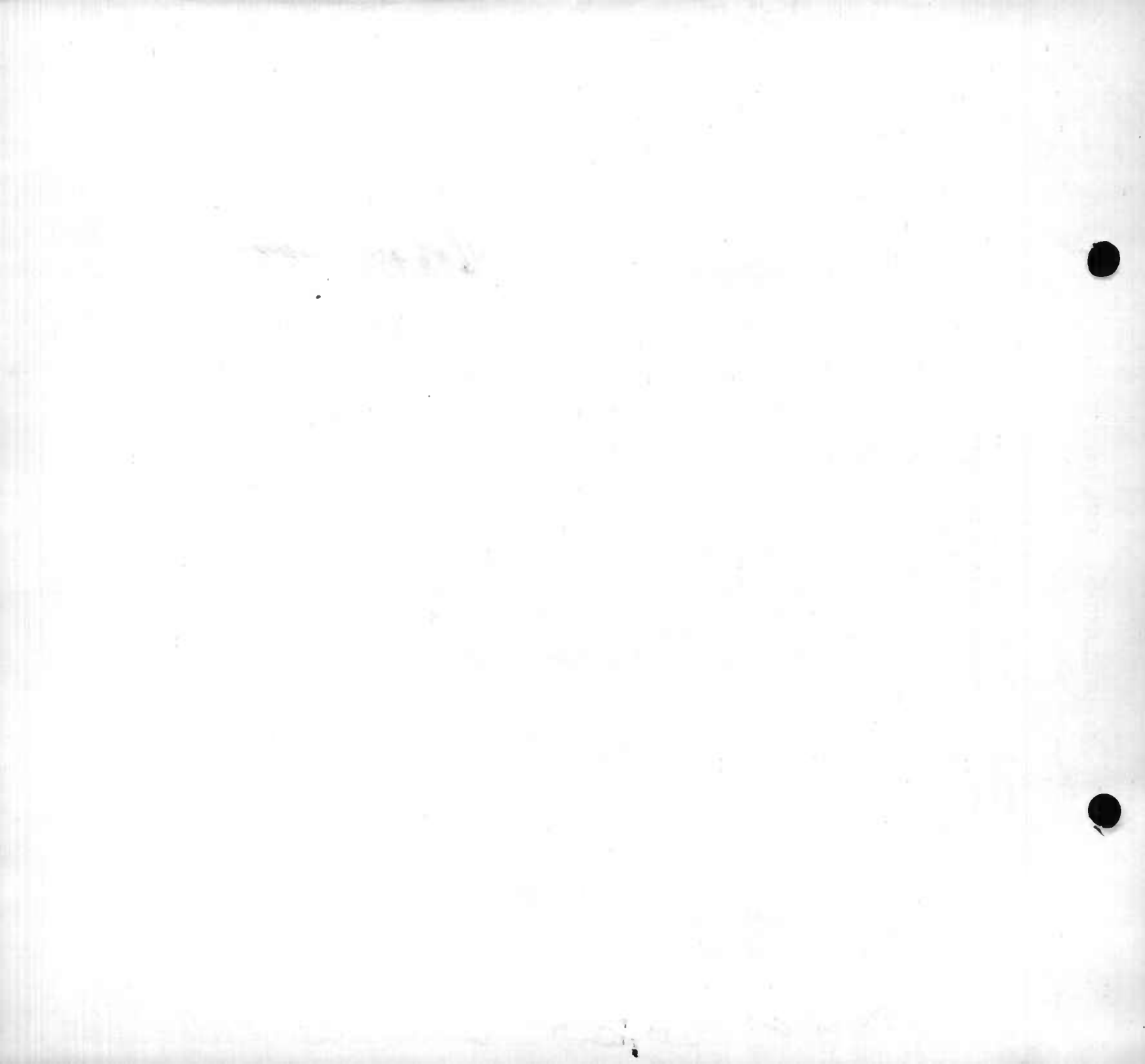
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

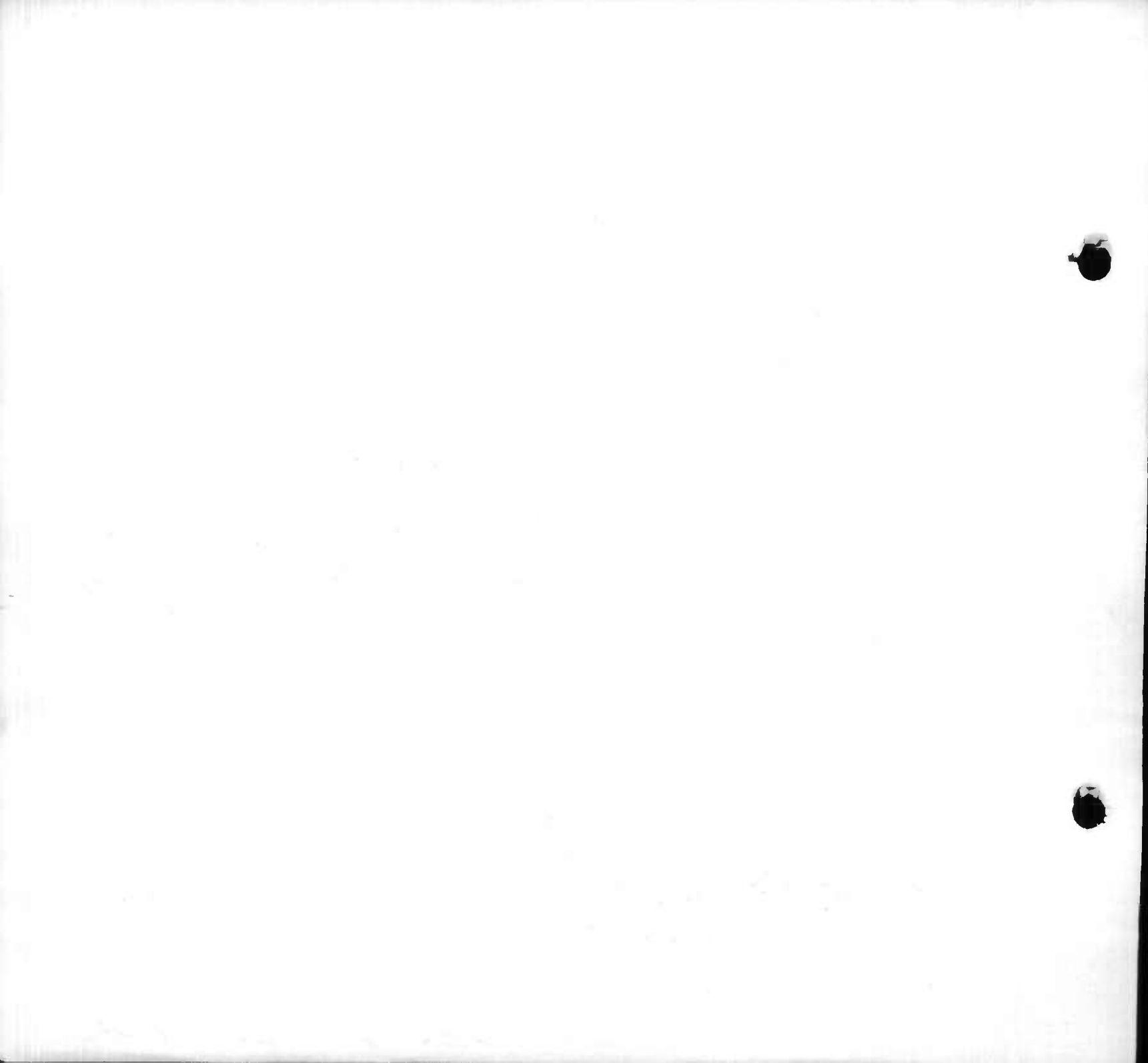
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3984	
1. NAME OF DECEASED (Type or Print) Robinson, Annie		2. DATE AND HOUR OF DEATH 4/5/70 1035 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE md. B. COUNTY 1601			
FULL NAME OF HOSPITAL OR INSTITUTION U. of Md. Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 38 919 N. Arlington					
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/1909	9. AGE (In years lost birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10B. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Unk.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) F-19		16. SOCIAL SECURITY NO. 30 099695030		17. INFORMANT Hubert Green	
ADDRESS Same					
18. 4/0.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Probable Coronary Artery Occlusion DUE TO, OR AS A CONSEQUENCE OF: (B) Past Hx. DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). (2) COA					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that My (this hospital) attended the deceased from 11/16 19 68 to 3/4 19 70 , that it (we) last saw the deceased alive on 3/4 19 70 and that in the (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel Hudson Barry MD		23B. DATE SIGNED 4/5/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 1712 W. North Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/9/70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR R. E. Taylor M.D.		25C. FUNERAL DIRECTOR L. P. Connell	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

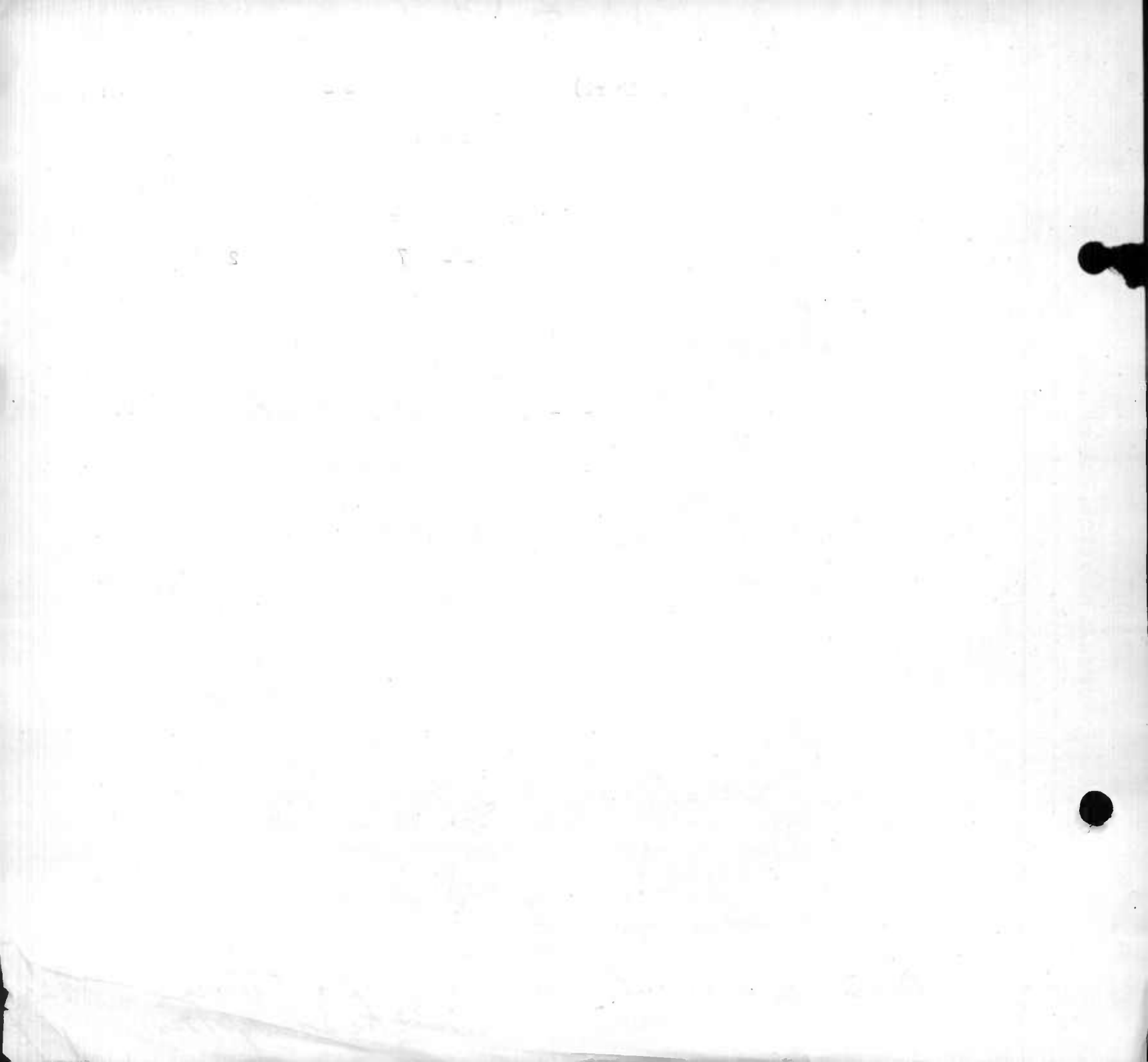
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3985	
BIRTH NO. 70 3985		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>RICHARD CHILES</u>		2. DATE AND HOUR OF DEATH <u>MAR 29, 1970</u> <u>11:50 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 UNIVERSITY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2101</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>540 W. BARRE ST</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 25-1920</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VA</u>	
13. FATHER'S NAME <u>JOHN CHILES</u>		14. MOTHER'S MAIDEN NAME <u>ANNA DEAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>57101</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bleeding Esophageal Varices</u> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) <u>Cirrhosis (Laennec's)</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Chronic Alcoholism</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>5 years</u> <u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indefinitely medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 29, 1970</u> to <u>March 29, 1970</u> that (I) (we) last saw the deceased alive on <u>March 29, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ronald S. Pototsky, M.D.</u>		23B. DATE SIGNED <u>MARCH 29, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>RONALD S. POTOTSKY M.D.</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>4/16/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Burial Mt. Calvary</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO MD 21201</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>		25B. NAME OF REGISTRAR <u>Ruby E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Wm. T. Small</u>		25D. ADDRESS <u>1712 W. North</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3986
BIRTH NO. 70 3986		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Melbert Clark (Malbert)		2. DATE AND HOUR OF DEATH 4-9-70 8:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Center		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1701 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 634 George Street		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-1897	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert M. Clark		
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 213-20-1826		17. INFORMANT Evelyn Clark 5330 Hamlin Ave		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of pancreas - 2 month		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral vascular accident - 1 day. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION Feb. 76		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Biopsy - open		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3/17 1970 to 4/9 1970 , that (I) (we) last saw the deceased alive on 4/8 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Edwin C. Dulton MD		23B. DATE SIGNED 4/9/70		23C. PHYSICIAN'S NAME (Type) Edwin C. Dulton MD
23D. ADDRESS		23E. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/11/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) Baltimore		24E. LOCATION (City, town, or county) Baltimore		
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Fisher MD		25C. FUNERAL DIRECTOR Washington & Shiloh 1727 N. Mount St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3987</u>	
H-125 70 3987				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>THELMA HOPKINS</u>				4-10-70 12 ⁴⁰ A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITAL</u> 4940 Eastern Ave., Balto. Md., 21224				A. STATE <u>MARYLAND</u> B. COUNTY <u>MARYLAND</u> C. CITY OR TOWN <u>Baltimore, Maryland</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3725 MT. PLEASANT AVE</u> 21224	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-5-09</u>	9. AGE (In years last birthday) <u>60</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Henry Meyer</u>			14. MOTHER'S MAIDEN NAME <u>Ellen</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT BCH Records: 4940 Eastern Ave. Balto. Md., 21224
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>412.4 I</u> <u>CARDIORESPIRATORY ARREST</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>~ 30 min</u> <u>~ 20 yrs</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-4-70</u> 19 <u>70</u> to <u>4-10</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>4-10</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. K. Maza MD.</u>				23B. DATE SIGNED <u>4-10-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. K. Maza, MD</u>				23D. ADDRESS <u>Balto. City Hospitals Balto. MD., 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/13/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cem.</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. NAME OF REGISTRAR <u>John E. Taylor, Jr.</u>		24F. FUNERAL DIRECTOR <u>J. W. Zarnier</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 15 1970</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>J. W. Zarnier</u>	
25D. ADDRESS <u>263 S. Connelley St.</u>					

B-525

70 3988

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 3988

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) J. JETHRO BENJAMEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 13 1970 12:45 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 9/13/04		10. AGE (In years lost birthday) 65	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S. Post Office	
13. FATHER'S NAME Jethro Benjamin		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2643	
15. MOTHER'S MAIDEN NAME Amanda Ireman		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 213-10-0020		18. INFORMANT Hilda Zurll Benjamin, wife, above	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 41241		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 4/15/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-13-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/70	
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR R. E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

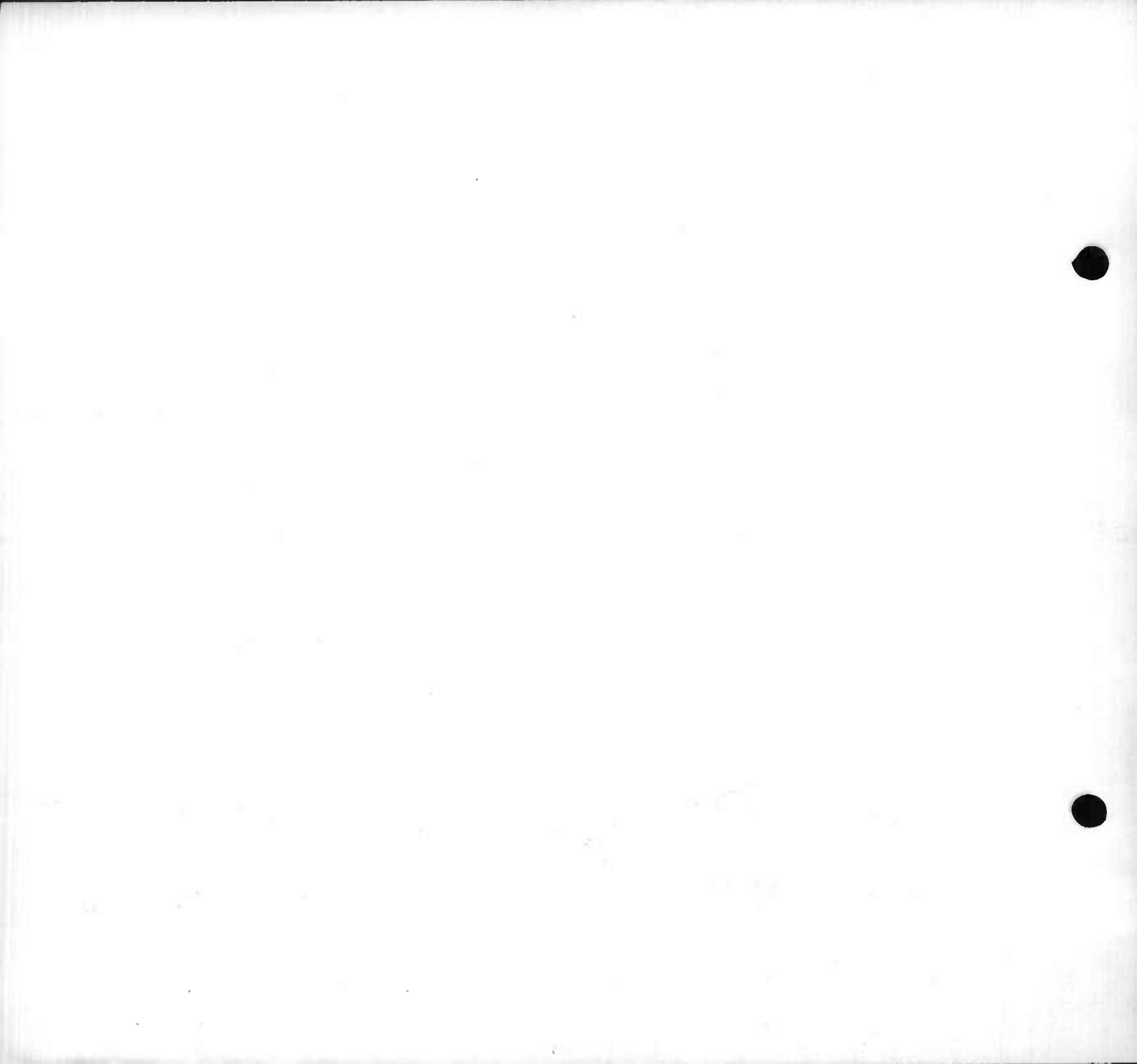
P-2361

70 3989

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 3989

BIRTH NO.		1. NAME OF DECEASED (Type or Print) PAZDERA, WILLIAM FRANK		2. DATE AND HOUR OF DEATH 4/12/70 1:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 21214		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL BALTIMORE, MD.			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 5002 CROSSWOOD AVE.		
5. SEX M	6. RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/04	9. AGE (in years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLOTHING CUTTER		10B. KIND OF BUSINESS OR INDUSTRY Lebo Bros.		11. BIRTHPLACE (State or foreign country) MD. Baltimore	
13. FATHER'S NAME ALNOIS PAZDERA			14. MOTHER'S MAIDEN NAME KATHERINE CEJOLE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-03-9218		17. INFORMANT ADDRESS Anna Koenigsmark Pazdera, wife, above	
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE: BARIAC ARREST (B) PULMONARY COLLAPSE (C) PULMONARY TB					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PERFORATED ILLIAL ULCER					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4/6/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE ABDOMEN		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/4 19 70 to 4/12 19 70 that (1) (we) lost soul the deceased alive on 4/12 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David M. Cook				23B. DATE SIGNED 4/12/70	
23C. PHYSICIAN'S NAME (Type) DEGREE		23D. ADDRESS DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/16/70		24C. NAME of CEMETERY or CREMATORY Bohemian National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Paul E. Fisher, M.D.		25C. FUNERAL DIRECTOR Schmuneck Funeral Home, Inc.	
				ADDRESS 3331 Brehms Lane	



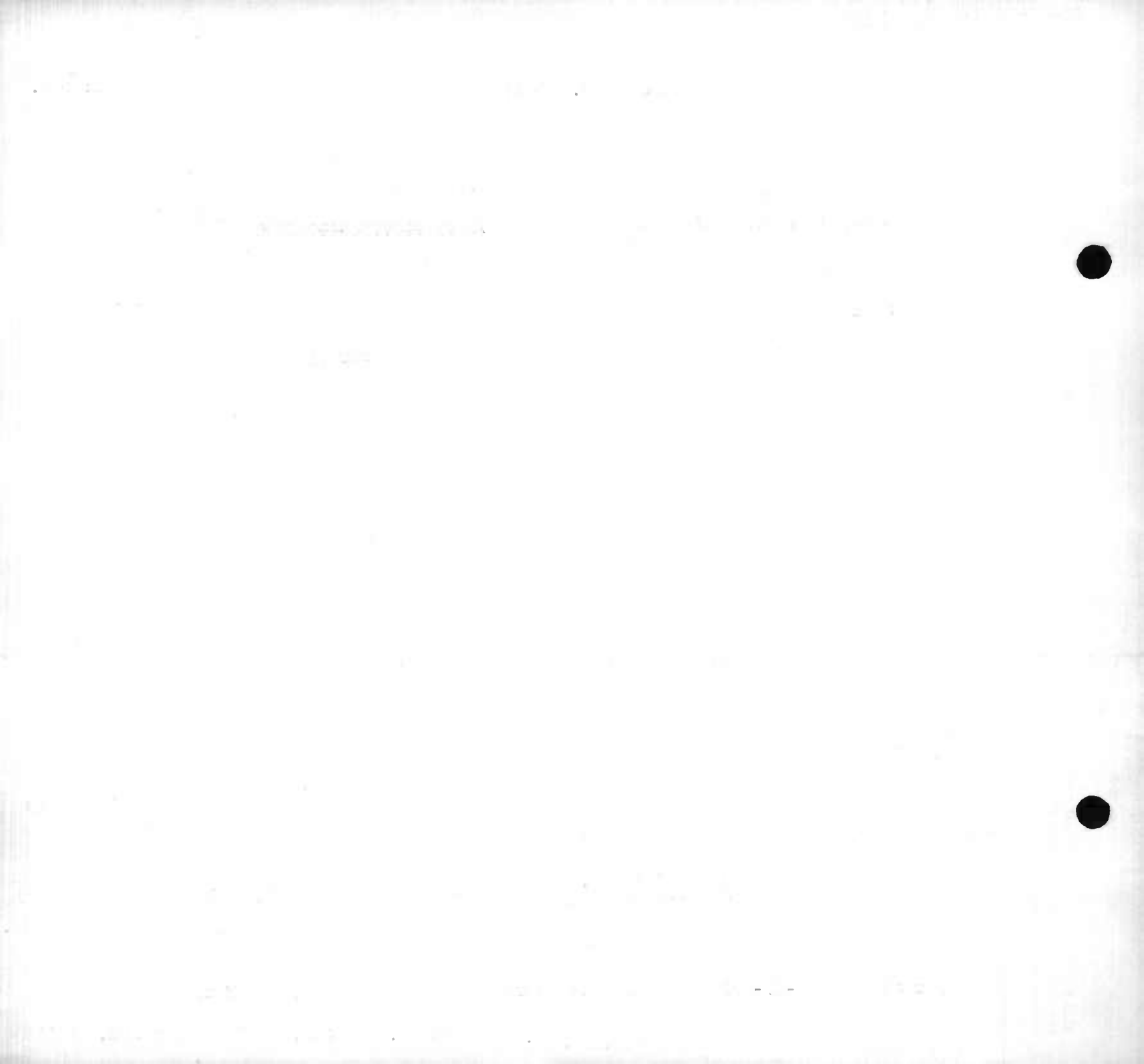
CERTIFICATE OF DEATH

REG. NO. 70 3990

BIRTH NO. 70 3990		2. DATE AND HOUR OF DEATH 4/14/70 5:45 A.M.	
1. NAME OF DECEASED (Type or Print) DORIS XXXXXX E. JONES		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE New York B. COUNTY V-29 C. CITY OR TOWN Binghamton D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER XXXXX F. ZIP CODE 13903 RFD 1	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-22 9. AGE (in years, lost birthday) 47 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Stanley Jones		14. MOTHER'S MAIDEN NAME Willo Merrill	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE 6 mo DUE TO, OR AS A CONSEQUENCE OF: influenza infections (B) LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF: 1-2 yrs. (C)	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/8 1969 to 4/14 1970 that (I) (we) last saw the deceased alive on 4/14 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE E. J. Hubbard Jr. M.D.		23B. DATE SIGNED 4/14/70	
23C. PHYSICIAN'S NAME (Type) Edward J. Hubbard Jr. M.D.		23D. ADDRESS BCH: 4940 Eastern Avenue Baltimore, Md. 1519 E. MONUMENT STREET, BALT. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-1970	
24C. NAME OF CEMETERY OR CREMATORY Conklin Cemetery		24D. LOCATION City, town, or county (State) Conklin, New York	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR		ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3991	
<div style="display: flex; justify-content: space-between;"> A-412 70 3991 CERTIFICATE OF DEATH </div>					
BIRTH NO. 70 3991					
1. NAME OF DECEASED (Type or Print) MARY A. ALBIKER			2. DATE AND HOUR OF DEATH April 11, 1970 3:45 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Hood Nursing Home 5213 Edmondson Avenue			A. STATE Maryland B. COUNTY Baltimore		
			C. CITY OR TOWN Halethorpe D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER 5639 Oakland Road		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1884	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Wortman		14. MOTHER'S MAIDEN NAME Elizabeth Weisman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Leona Atkinson, 5639 Oakland Rd. 21227	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Atherosclerotic Cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Osteoarthritis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-10-1956 to 4-11-1970 , that (I) (we) lost saw the deceased alive on 4-11-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry L. Knipp				23B. DATE SIGNED 4-13-70	
23C. PHYSICIAN'S NAME (Type) Dr. Harry L. Knipp				23D. ADDRESS 4116 Edmondson Avenue, Balto., Md. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-15-70		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

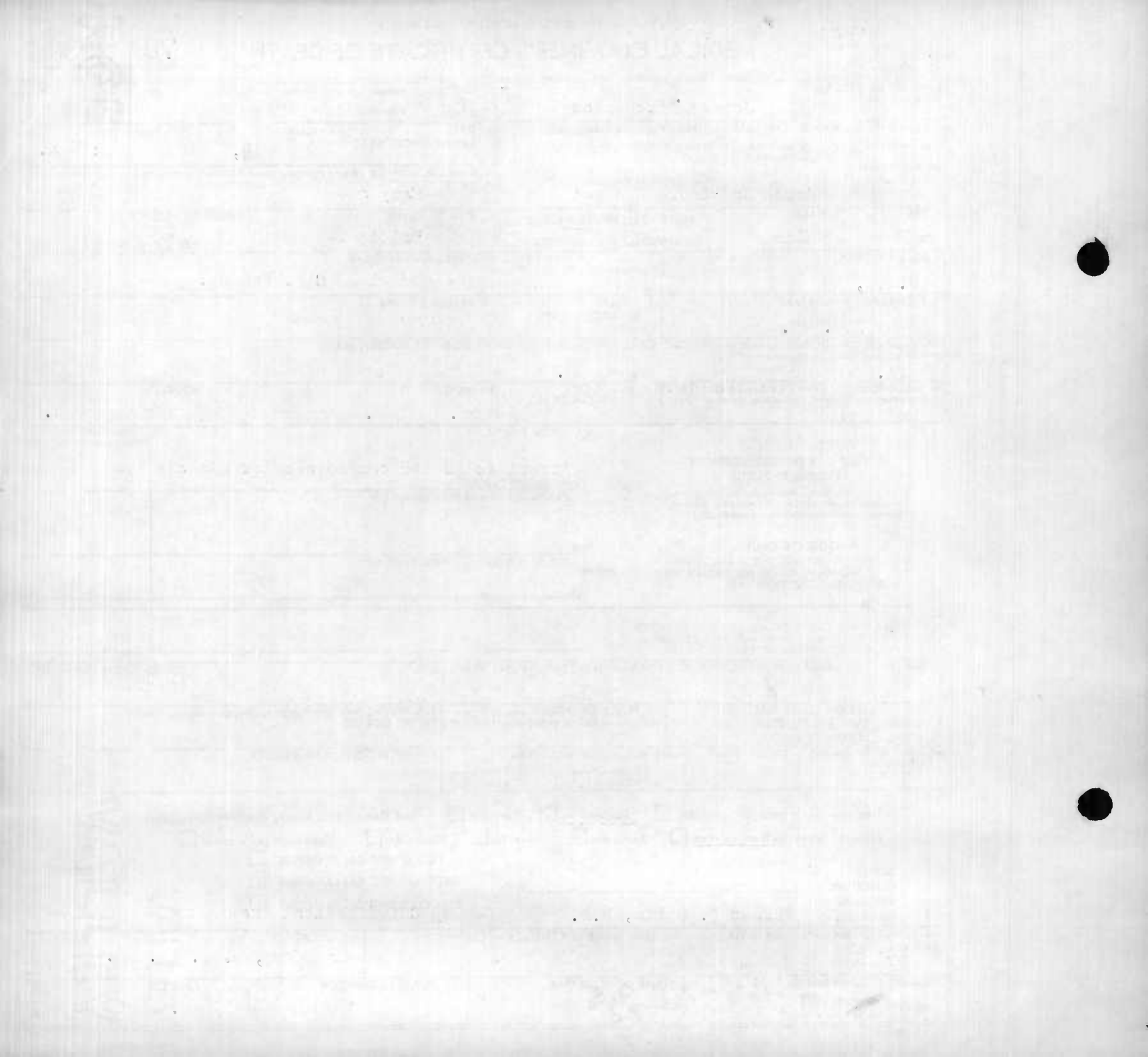
E-163		70 3992		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 3992	
1. NAME OF DECEASED (Type or Print) JESSIE EBERT				2. DATE AND HOUR OF DEATH APRIL 12, 1970 11:45 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY FREDERICK C. CITY OR TOWN FREDERICKS D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 147 W. PATRICK STREET					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 8, 1904	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) FREDERICK, MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME NOT KNOWN Edward C. Ebert				14. MOTHER'S MAIDEN NAME NOT KNOWN Annie Neff					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219 32 1176		17. INFORMANT ADDRESS HOSPITAL RECORD, UNION MEMORIAL HOSP.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH OVARIAN CARCINOMA WITH INTRA-ABDOMINAL CARCINOMAS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from APRIL 4 1970 to APRIL 12 1970 that (I) (we) last saw the deceased alive on APRIL 12 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Victorino S. Yu, M.D.				23B. DATE SIGNED 4-12-70		23C. PHYSICIAN'S NAME (Type) VICTORINO S. YU, M.D.			
23D. ADDRESS UNION MEMORIAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial							
24B. DATE 4-12-70		24C. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		24D. LOCATION (City, town, or county) (State) FREDERICK FREDERICK MD.		25A. DATE REC'D BY HEALTH DEPT. APR 15 1970			
25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR ADDRESS M. R. Etchison & Son, Frederick, Md.							

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 3993

BIRTH NO.

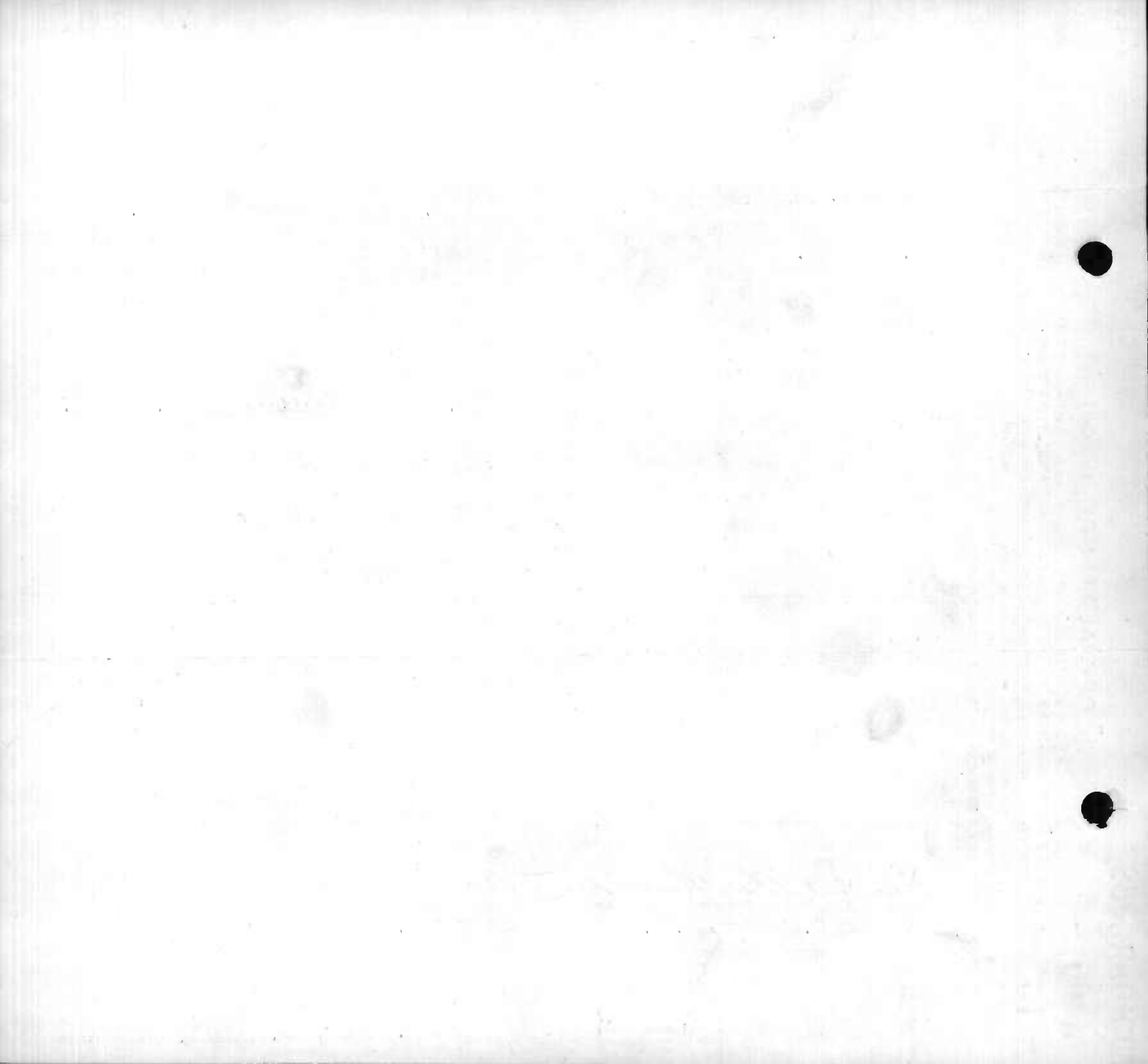
1. NAME OF DECEASED (Type or Print) James B. Herchenhan		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 14 70 3:15 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 14 70 3:15 a. M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY 2303	
9. DATE OF BIRTH Nov. 25, 1905		10. AGE (In years last birthday) 64 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Herchenhan		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prod. Manager	
15. MOTHER'S MAIDEN NAME Rose Magee		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Ruth V. Herchenhan	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ACTUAL SIGNATURE: Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		DATE SIGNED 4/14/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4 17 70	
24C. NAME OF CEMETERY or CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 15 1970		25B. NAME OF REGISTRAR Paul E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Hq. Gully		ADDRESS 130 E. Fort Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
M-536 70 3994		70 3994			
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <i>Louise Denton Mundorf</i>			2. DATE AND HOUR OF DEATH <i>April 14, '70</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>601</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 25 N. Linwood Avenue</i>			C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <i>25 N. Linwood Avenue</i>					
5. SEX <i>F.</i>	6. RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/26/'88</i>	9. AGE (In years lost birthday) <i>82</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>John Thiess</i>			14. MOTHER'S MAIDEN NAME <i>Matilda Rebbel</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Mrs. Matilda Feathers 3834 S. 6th St.</i>
18. <i>250171</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumonia rt lower lobe</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertensive C V Dis</i> (C) <i>Diabetes mellitus</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 19 68</i> to <i>April 13</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>April 13</i> , 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles C. MacMinn M.D.</i>				23B. DATE SIGNED <i>April 14, 1970</i>	
23C. PHYSICIAN'S NAME (Type) <i>Charles C. MacMinn, M. D.</i>				23D. ADDRESS <i>2900 E. Baltimore Street</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/18/'70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>APR 15 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran, Inc. 3000 E. Baltimore St</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-620 70 3995		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 3995	
1. NAME OF DECEASED (Type or Print)		GRACIE, LESTER JAMES		2. DATE AND HOUR OF DEATH APRIL 14, 1970 4:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE B. COUNTY		5. CITY OR TOWN D. INSIDE CITY LIMITS?	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		RANDALLSTOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ST AGNES HOSPITAL		E. STREET AND NUMBER		3620 TEMPLAR ROAD	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	WHITE		09 11 09	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
SHIPPING MANAGER				PENNSYLVANIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
THOMAS GRACIE		SARAH WHITTLE		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES W.W.2		212-05-2427		CATON & WILKENS AVES ST AGNES HOSP BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Carcinoma of the head of Pancreas	
		(B) DUE TO, OR AS A CONSEQUENCE OF:		Obstructive jaundice due to No. 1	
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
1 Month () Day () Year () Hour ()		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from MARCH 24 19 70 to APRIL 14 19 70 that (X) (we) last saw the deceased alive on APRIL 14 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
A. SHAMS, M.D.		9-14-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
A SHAMS, M.D.		BALTO MD 21229 ST AGNES HOSPITAL, CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4/18/70		New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 16 1970		J. E. Vailley, M.D.		Witzke, 1630 Edmondson Avenue	

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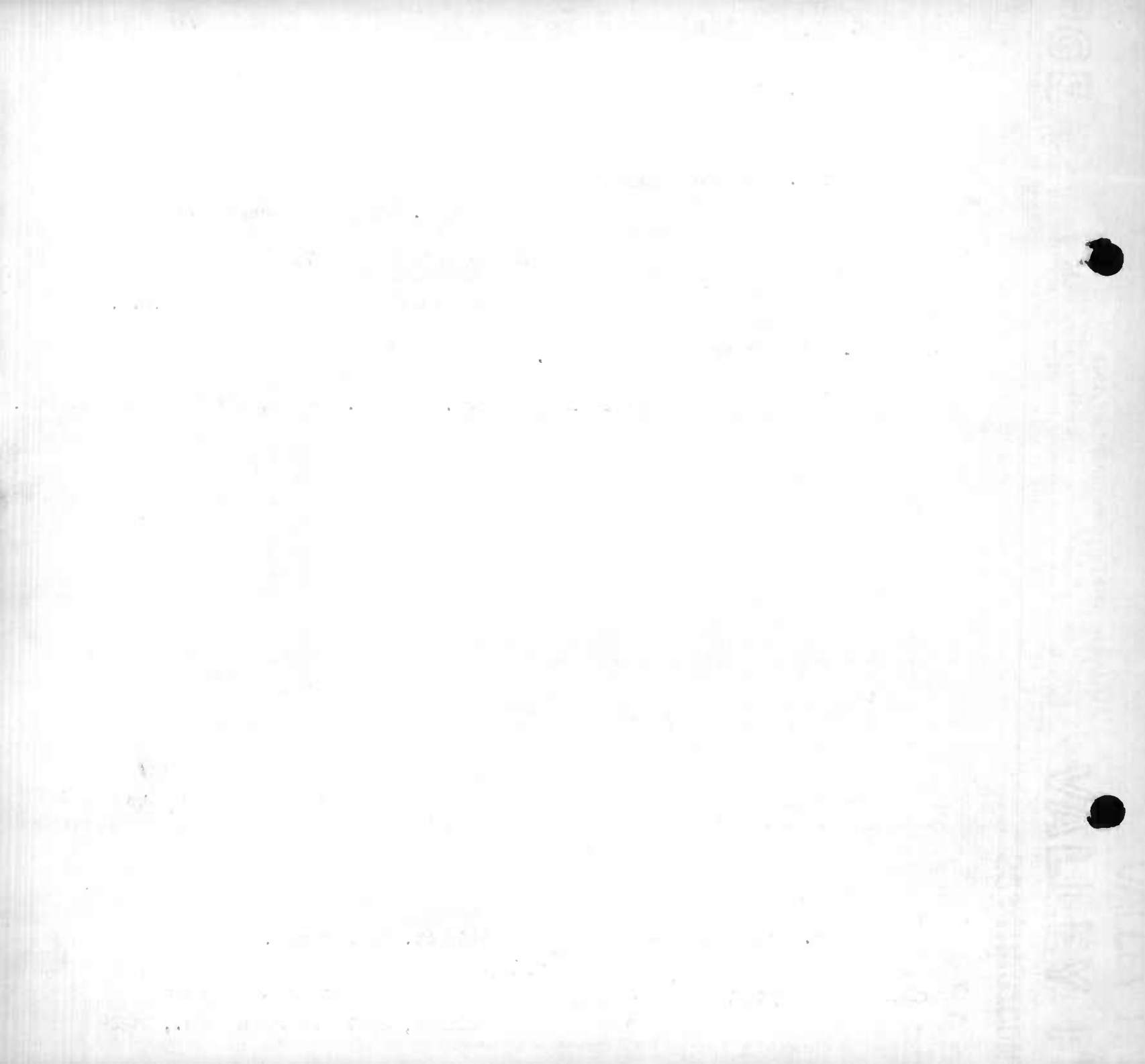
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3996	
<div style="display: flex; justify-content: space-between;"> S-351 70 3996 </div>					
BIRTH NO.			1. NAME OF DECEASED (Type or Print)		
			Wm. Ralph Stonebraker		
2. DATE AND HOUR OF DEATH			4/13/70 7:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 115 E. Lafayette Street Avenue			A. STATE Md		
			B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 115 E. Lafayette Street Avenue			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 115 E. Lafayette Street		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/16/1895	9. AGE (In years lost birthday) 75	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph W. Stonebraker			14. MOTHER'S MAIDEN NAME Laura		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-16-8044	17. INFORMANT Mrs. Laura I. Dunbar, 517 Chestnut Hill Ave.		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			ACUTE MYOCARDIAL INFARCTION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIO SCLEROSIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 25 1969 to April 13 1970, that (I) (we) last saw the deceased alive on Dec 23 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Frank Supplee III				23B. DATE SIGNED 4/14/70	
23C. PHYSICIAN'S NAME (Type) Dr. Frank Supplee				23D. ADDRESS 1010 St. Paul Street.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/16/70		24C. NAME OF CEMETERY or CREMATORY Rose Hill	
24D. LOCATION Hagerstown, Maryland		24E. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229	
25A. DATE REC'D BY HEALTH DEPT. APR 16 1970		25B. NAME OF REGISTRAR		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 3997 4</u>	
R-543 70 3997				CERTIFICATE OF DEATH	
BIRTH NO. <u>70-04424</u>		3997			
1. NAME OF DECEASED (Type or Print) <u>Baby boy Reynolds.</u>			2. DATE AND HOUR OF DEATH <u>March 17 1970 10:10 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2505</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital</u> <u>43</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1519 Popland St</u>		
5. SEX <u>M</u>	6. RACE <u>C W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-17-70</u>	9. AGE (In years last birthday) <u>18 MIN</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Luther</u>			14. MOTHER'S MAIDEN NAME <u>Charlotte Reynolds</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>777 X I</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) _____ DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-17</u> 19 <u>70</u> to <u>19 70</u> that (I) (we) last saw the deceased alive on <u>3-17</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Eleanor L. Moon MD</u>				23B. DATE SIGNED <u>3-18-70</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-14-70</u>		24C. NAME of CEMETERY or CREMATOR <u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 16 1970</u>		25B. NAME OF REGISTRAR <u>Robert F. Taylor MD</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u>	

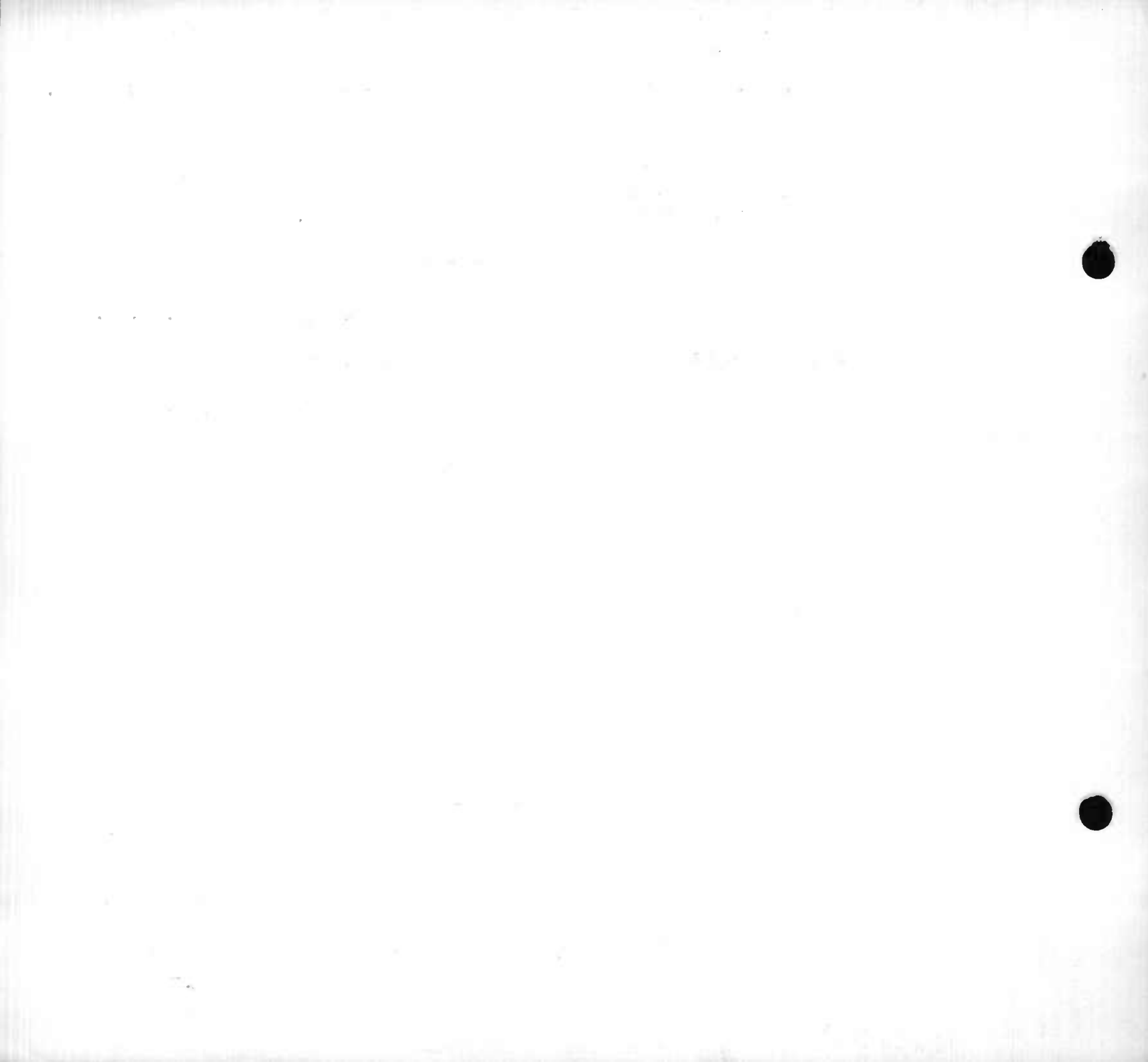
FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 3998	
BIRTH NO. 70-04832 3998		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 3998	
1. NAME OF DECEASED (Type or Print) Baby Boy KETNOR		2. DATE AND HOUR OF DEATH 3-21-70 3:26 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South BALTO. GEN. Hosp.		A. STATE 1		B. COUNTY 2404	
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-19-70		9. AGE In years (last birthday) 1 10		10. UNDER 1 Yr. Months: Days: 1 10	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Cecil Ketnor		14. MOTHER'S MAIDEN NAME Carolyn Forrester	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hyaline Membr. Dis.			
		(B) Rheumatism DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 3-19-70 to 3-21-70 that (I) (we) lost saw the deceased alive on 3-21-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Melocoton MD		23B. DATE SIGNED 3-21-70		23C. PHYSICIAN'S NAME (Type) ALEJDE A MELOCOTON	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 4-14-70		24C. NAME OF CEMETERY or CREMATORIAL SOCIETY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 16 1970		25D. ADDRESS		25E. LOCATION	
		UNIVERSITY MEDICAL SCHOOL		MORTUARY SERVICE - BCHD	

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<p>M-260 70 3999</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 70 3999</p>	
<p>1. NAME OF DECEASED (Type or Print) McCrae, Bo. Thomasine</p>		<p>2. DATE AND HOUR OF DEATH 4-9-70 10:10 P. M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital 1514 Divison Street Baltimore, Maryland 21217</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1402</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 1413 Argyle Ave.</p>	
<p>5. SEX Female</p>	<p>6. RACE Negro</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 4-9-70</p>
<p>9. AGE (In years last birthday) 40</p>		<p>If Under 1 Yr. Months Days If Under 24 Hrs. Min. 2 40</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) Baltimore Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>	
<p>13. FATHER'S NAME Jerome Diggs</p>		<p>14. MOTHER'S MAIDEN NAME Thomasine McCrae</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT Miss Thomasine McCrae-Mother</p>		<p>ADDRESS Same</p>	
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Immaturity</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) No</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 4-9-70 to 4-9-70 that (I) (we) last saw the deceased alive on 4-9-70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE L. Estella M.D.</p>		<p>23B. DATE SIGNED April 10, 1970</p>	
<p>23C. PHYSICIAN'S NAME (Type) LORY ESTELLA M.D.</p>		<p>23D. ADDRESS 1514 Divison Street Baltimore, Maryland</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) 4-14-70</p>		<p>24B. DATE 4-14-70</p>	
<p>24C. NAME OF CEMETERY or CREMATORY</p>		<p>24D. LOCATION (City, town, or county) (State) ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. APR 16 1970</p>		<p>25B. NAME OF REGISTRAR Robert E. Talley M.D.</p>	
<p>25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD</p>		<p>ADDRESS</p>	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>M-324</u> <u>70-0656270</u> <u>4000</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70</u> <u>4000</u> <u>4</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Mitchell</u>			2. DATE AND HOUR OF DEATH <u>April 11, 1970</u> <u>1:45</u> <u>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>9 PROVIDENT HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2833</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>9 PROVIDENT HOSPITAL</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2111 Crimen Road Avenue</u>		
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-70</u>	9. AGE (in years last birthday) <u>5</u> <u>15</u> <u>19</u>	10. Under 1 Yr. Months: <u>5</u> Days: <u>15</u> Hours: <u>19</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>GARY L. MITCHELL</u>		
14. MOTHER'S MAIDEN NAME <u>EVERLYN DILBY</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Evelyn Mitchell- Mother</u>		
18. ADDRESS <u>SAME</u>			19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Prematurity</u>		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			21. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Prematurity</u>		
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			23. DUE TO, OR AS A CONSEQUENCE OF: <u>(B) _____</u> <u>(C) _____</u>		
24. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>		
20A. AUTOPSY? (Yes or No) <u>No</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>April 5</u> 19 <u>70</u> to <u>April 11</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>April 11</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L. Estella M.D.</u>			23B. DATE SIGNED <u>April 11/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>LORY ESTELLA M.D.</u>			23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>		
24A. BURIAL CREMATION REMOVAL (Specify) <u>4-14-70</u>			24B. DATE <u>4-14-70</u>		
24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>			24D. LOCATION <u>MORTUARY SERVICE - BCHD</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 16 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Barber, R.D.</u>		
25C. FUNERAL DIRECTOR			25D. ADDRESS		

2111crimea Rd.